63969

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 63869

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 5

(No. U.S. Veterans' Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Andrew J. Wilson

(a) Residence. No. ... St. Eden, Idaho
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lillie Wilson

6. DATE OF BIRTH (month, day and year) 10-10-1875

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	2	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kans.

PARENTS

10. NAME OF FATHER Daniel Wilson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va.

12. MAIDEN NAME OF MOTHER Margaret Bart

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Va.

14. Informant D.W.Herron
(Address) U.S.V.Hospital, Boise, Idaho

15. Filed 1/8, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 6, 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1928, 19..., to Jan.6,1929, 19...
that I last saw h. im alive on Jan.6,1929, 19...
and that death occurred, on the date stated above, at 8:50 PM m.
The CAUSE OF DEATH* was as follows:
General Peritonitis

xx (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) none

xx (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? Yes Date of 12-28-28
Was there an autopsy? Yes
What test confirmed diagnosis? xx

(Signed) F.B. Brewer, M. D.
Jan.7,1929, 19... (Address) MEDICAL OFFICER in CHARGE
U.S. VETERANS' HOSPITAL
BOISE, IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise, Idaho	1-8-29 19
20. Undertaker W.McBratney	Address Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REGISTERED JAN 29 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64208

PLACE OF DEATH

County of Ada

City of Boise

Registration District No.

Primary Registration District No. 1004

Local Registrar's No. 10

(No. U. S. Veterans' Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Storey

(a) Residence. No. Soldiers Home St. Boise, Idaho
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 12 ds. (Usual place of abode) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of XX

6. DATE OF BIRTH (month, day and year) March 17, 1848

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	10	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ark.

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant D. W. Herron

(Address) U.S.Veterans' Hospital, Boise, Idaho

15. Filed Jan 31, 1929 Paula McBaines Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 18, 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1929, 19..., to Jan. 18, 1929, 19...
that I last saw him alive on Jan. 18, 1929, 19...
and that death occurred, on the date stated above, at 8:50 P. m.
The CAUSE OF DEATH* was as follows:

Cardiac failure

XX (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

XX (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? XX

(Signed) F. B. BREWER, M. D.
Jan. 19, 1929, 19... (Medical OFFICER IN CHARGE U. S. VETERANS' HOSPITAL BOISE, IDAHO)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Boise, Idaho	19 1-21-29
20. Undertaker W. McBratney	Address Boise, Idaho

64309

RECEIVED JAN 29 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64309

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 6

(No. U.S. Veterans' Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Jefferson Yeates

(a) Residence. No. 1706 North 10th St. St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Tillie Yeates

6. DATE OF BIRTH (month, day and year) May 27, 1845

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	83	7	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10. NAME OF FATHER Wilson W. Yeates

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant D.W.Herron
(Address) U.S.V.Hospital, Boise, Idaho

15. Filed 1-17-, 1929 Laula M. Howard
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 15, 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1928, 19, to Jan. 15, 1929, 19
that I last saw him alive on Jan. 15, 1929, 19
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis, generalized

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? XX

(Signed) F. R. BREWER, M. D.
PHYSICAL OFFICER IN CHARGE
U. S. VETERANS' HOSPITAL
BOISE, IDAHO

Jan. 16, 1929, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill, Boise, Idaho	1-17-29 19
20. Undertaker W.McBratney	Address Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

64314

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64314

PLACE OF DEATH RECEIVED FEB 7 1929

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 41
(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Francis A. Nafie
(a) Residence. No. Central Hotel St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): 1881

7. AGE: 48 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Idaho Power

9. BIRTHPLACE (city or town) (State or country): Hoboken New Jersey

PARENTS

10. NAME OF FATHER: Alexander B Nafie
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mass.
12. MAIDEN NAME OF MOTHER: Melissa Mlnell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mass

14. Informant: Robert J. Nafie
(Address)

15. Filed 1-31-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 29 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1929, to Jan 29, 1929
that I last saw him alive on Jan 29, 1929
and that death occurred, on the date stated above, at 9 p.m.
The CAUSE OF DEATH* was as follows:
Bilateral Broncho-Pneumonia.
Type I Pneumococcus.
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary): Ac. Myocard. failure
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Sputum - lab
(Signed) Ralph Falk /x M. D.
Jan 30 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Jan. 31 1929
20. Undertaker: Summers & Krebs
Address: Boise Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

64315

FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64315

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

2. FULL NAME S Wa Cole
(a) Residence. No. Vancouver Wash St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Widower
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): July 27-1868
7. AGE: 61 Years, 5 Months, 16 Days. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Ireland

PARENTS
10. NAME OF FATHER: Martin Cole
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Wa Cole Jr.
(Address): Vancouver Wash

15. Filed 2-8-, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Body found dead in Hotel Room
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Acute Cardiac dilation
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) F E Drake Coroner M. D.
....., 19..... (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Vancouver Wash
Date of Burial: Jan 23 1929
20. Undertaker: F E Drake
Address: Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

State of Oregon)
)ss.
County of Multnomah)

I, Eliza Jane Thorp, being first duly sworn, do depose and say as follows:

I am the sister of Samuel William Andrew Cole, whose dead body was found on January 21st, 1929 in an hotel room at Twin Falls, Idaho. I have in my possession the family Bible which contains the record of the marriage of my father and mother and a complete record of the births of the respective children, my six brothers and one sister. That this record, in the handwriting of my father, records the birth of his sixth child, Samuel William Andrew Cole, on the 27th day of July, 1868, at Creevaugh, Ballybay, County of Monaghan, Ireland.

Eliza Jane Thorp

Subscribed and sworn to before me this 15 day of February, 1929.

A. L. Coleman

NOTARY PUBLIC FOR OREGON
MY COMMISSION EXPIRES AUG 22, 1930

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 7 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64317

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2008

Local Registrar's No. 1

(No. Ada County Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Libbie Case.

(a) Residence. No. I308 Bannock St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 6 Wks. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Case.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oxbridge, Ontario, Canada.

PARENTS

10. NAME OF FATHER --------Fralick.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada.

12. MAIDEN NAME OF MOTHER Don't Know.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant W. R. Case.

(Address) II2I Lee Street.

15. Filed 1-14-, 1929 Paula McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 8th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8th, 1929, to Jan 8th, 1929
that I last saw her alive on Jan 7th, 1929
and that death occurred, on the date stated above, at P.M.

The CAUSE OF DEATH* was as follows:

~~Cerebral~~ Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemmorrhage

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? Ada County

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. M. Braffan M. D.

I/9/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	I/II/29 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64318

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2008

(No. Ada Co Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

2. FULL NAME Frank O'Conner

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1840

7. AGE Years 88 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Stock Raiser

(c) Name of employer and Miner.

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant A. Schreiber
(Address) Boise

15. Filed Jan 24, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Jan 22, 1929 that I last saw him live on Jan ~~22~~ 21, 1929 and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:
Epithelioma of Face.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of Femur & Lobar Pneumonia Fell down 2 weeks previously on ice (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ada County

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) T. N. Brattan, M. D.

Jan 23, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St John's Cemetery | Date of Burial 1/24 1929

20. Undertaker Schreiber & McCann | Address Boise 2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64319

PLACE OF DEATH FEB 7 1929

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No.)
Local Registrar's No. 1

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edna Grace Fletcher

(a) Residence. No. 1200 N 18 St.
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 9 1870

7. AGE: Years 58 | Months 10 | Days 5 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: Gilman F. Fletcher
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Vermont
12. MAIDEN NAME OF MOTHER: Martha L. Robinson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa,

14. Informant: Mrs. M. S. Fletcher
(Address) 1200 N. 18 street Boise Idaho

15. Filed 1-16-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 14 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8th, 1928, to the Jan. 14th, 1929
that I last saw her alive on Jan 14th, 1929
and that death occurred, on the date stated above, at 4. P m.
The CAUSE OF DEATH* was as follows:
Thrombus of Brain
Coma

(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Chronic Nephrocolitis
Several years (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical only
(Signed) J. M. Taylor, M. D.
1/15-, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Jan 16 1929
20. Undertaker: Summers & Krebs — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64320

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 12

2. FULL NAME Minnie Pearl Commons

(a) Residence. No. Consumers Utah St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Wht	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Clarence Commons

6. DATE OF BIRTH (month, day and year) Mar 14 1890

7. AGE	Years	Months	Days	If LESS than 1 day,
	38	9	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gem Station Ark.

PARENTS

10. NAME OF FATHER James Hugley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Cora Reed
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Clarence Commons
(Address) Price Utah

15. Filed 1-15-, 1929 Paula McDowell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/7, 1929, to 1/10, 1929
that I last saw her alive on 1/10, 1929
and that death occurred, on the date stated above, at 5 [illegible] m.
The CAUSE OF DEATH* was as follows:
Cancer of breast & lungs.
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Glens Ferry
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) A J Coats, M. D.
1/11, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Price Utah	1-15 1929
20. Undertaker SCHREIBER & MCCANN	Address Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 7 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64321

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 3

(No. St Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Gillett

(a) Residence. No. 1109 E Jefferson St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 24-1861

7. AGE: 67 Years, 6 Months, 22 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS

10. NAME OF FATHER: Eli Gillett

11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York

12. MAIDEN NAME OF MOTHER: Ann, Anscomb

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Michigan

14. Informant: Mrs John R Hall
(Address) 1109 E. Jefferson St. Boise Ida

15. Filed 1-17-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 16th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1928, to Jan 16th, 1929 that I last saw him alive on Jan 15th, 1929 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus of Stomach

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Bank, M. D.

Jan 16th 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Jan 17 1929

20. Undertaker: Summers & Krebs — Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 7 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64322

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 4

(No. St Alphonsus)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Magdalene Sherich

(a) Residence. No. 514 Washington St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 15 Sept. 15 - 1929

7. AGE Years | Months 4 | Days 10 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho

PARENTS

10. NAME OF FATHER Steve Sherich

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Austria

12. MAIDEN NAME OF MOTHER Helen Thomas

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Steve Sherich

(Address) 514 Washington

15. Filed 1-25-1929 Paula M. Donald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3 P.M. Jan 24, 1929, to Jan. 25, 1929

that I last saw her alive on Jan. 25, 1929

and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH was as follows:

Broncho-pneumonia

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? 514 Wash. St. Boise

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical findings

(Signed) Harmon Tremaine, M. D.

Jan. 26, 1929 (Address) 626 Eastman Bldg Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. John's Cemetery | Date of Burial: 1/28 1929

20. Undertaker: Schreiber & McCann | Address: Boise Ia

Tremaine

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64323

PLACE OF DEATH FEB 7 1929

County of Ada
City of Boise
Registration District No.
Primary Registration District No. 1004
Local Registrar's No. 2
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dorothy June Evans
(a) Residence. No. R R 4 Boise St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): June 30, 1926
7. AGE: Years 2 | Months 5 | Days 10 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Boise Idaho

PARENTS
10. NAME OF FATHER: Peter Evans
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Eureka Nevada
12. MAIDEN NAME OF MOTHER: Della Eichelberger
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Boise Ida.

14. Informant: Peter Evans
(Address): R R 4 Boise Ida
15. Filed Jan 27, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 26 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1929, to Jan 26, 1929
that I last saw h[illegible] alive on Jan 26, 1929
and that death occurred, on the date stated above, at 9 45 A. m.
The CAUSE OF DEATH* was as follows:
Acute septic Pyelo-Nephritis.
Prom (duration) yrs. mos. 30 ds.
CONTRIBUTORY (Secondary) Neisserian-pyelitis.
(duration) yrs. mos. 30 ds.
18. Where was disease contracted if not at place of death? At home
Did an operation precede death? Yes. Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? Laboratory and Post mortem
(Signed) Harmon A. Swenson M. D.
Jan 26, 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Jan 22 1929
20. Undertaker: Summers & Reed — Address: Boise Idaho

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64324

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 8

(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Georgiana Alloway

(a) Residence. No. Near Cole School St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of S. A. Alloway

6. DATE OF BIRTH (month, day and year) April 6, 1858

7. AGE: 70 Years | Months: 3 | Days: 13 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: G. N. Mathews

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Malissa Estes

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: J. F. Alloway
(Address) 1011 - No 8th St

15. Filed Jan 21, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 19th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 15th, 1928, to Jan 19th, 1929 that I last saw her alive on Jan 19th 1929 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Second attack —
Paralyzed —
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): First Stroke in 1928
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.
Jan 21st, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: Jan 22 1929

20. Undertaker: Summers & Krebs | Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64325

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 9

(No. Front street, between 6th & 7th street.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Yet Gum

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.

4. COLOR OR RACE Chinese.

5. Single, Married, Widowed, or Divorced (write the word) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year)

7. AGE Years About 80 | Months — | Days — | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) China.

PARENTS

10. NAME OF FATHER Don't Know.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Pearl Allen.
(Address) Boise, Idaho.

15. Filed Jan 21, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January. 15th 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ ----------, 19--, ~~to~~ ----------, 19--
~~that I last saw him alive on~~ ----------, 19--
~~and that~~ death occurred, on the date stated above, at ---- m.

The CAUSE OF DEATH was as follows:
Found Dead in Bed.
Natural cause. Had been in poor health for long time.
No Inquest held.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ——

Did an operation precede death? No. Date of ——

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm McBratney-Coroner ~~M. D.~~

I/18/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Cninese Cemetery. | Date of Burial I/17/29 19

20. Undertaker Wm. McBratney. | Address Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 7 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64326

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 11

(No. 419 South 15th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Mabelle Grace Whitney.

(a) Residence. No. 419 south 15th St.
(Usual place of abode)
Length of residence in city or town where death occurred. 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Howard H. Whitney.

6. DATE OF BIRTH (month, day and year) Sept. 29th 1882

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	3	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Muscatine, Iowa.

PARENTS

10. NAME OF FATHER Jacob Burnside.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Sibbie R. Rich.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa.

14. Informant Howard H. Whitney.

(Address) Boise, Idaho.

15. Filed 1-19-, 1929 Laura M. Bonnell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 18th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1927, to Jan. 18th, 1929
that I last saw h er alive on Jan 10th, 1929
and that death occurred, on the date stated above, at 5-30 a. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of right breast and chest.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Burk M. D.

Jan. 18th, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	1/20/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64327

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 12

(No. U.S.Veterans' Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anton Charley Schulhauser

(a) Residence. No. ..... St. Payette, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 15, 1889

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
39	8	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) xx

(c) Name of employer xx

9. BIRTHPLACE (city or town) (State or country) Wis.

PARENTS

10. NAME OF FATHER Charles Schulhauser

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Anna Meuveuer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant D.W.Herron

(Address) U.S.V.Hospital, Boise, Idaho

15. Filed Jan 23 1929 Paula McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 22, 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Aug. 24, 19 27, to Jan.22,1929, 19
that I last saw h im alive on Jan.22,1929, 19
and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis,pulmonary,chronic

unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Tbc Intestinal

unknown (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? xx

(Signed) ..... M. D.

Jan.23,1929, 19 (Address) F. B. BREWER
MEDICAL OFFICER IN CHARGE
U.S. VETERANS' HOSPITAL

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill,Boise,Idaho	1-24-29 19

20. Undertaker	Address
W.McBratney	Boise,Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 7 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64328

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 13

(No. 1308 N. 12th Street.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Louisa Jane Paddy.

(a) Residence. No. 1308 N. 12th St.
(Usual place of abode)
Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of John E. Paddy.

6. DATE OF BIRTH (month, day and year) Oct. 18th 1851

7. AGE Years	Months	Days	If LESS than 1 day, ~~hours~~ min.
77	2	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norwood, Hastings Co. Ontario, Canada.

PARENTS

10. NAME OF FATHER Jonathan Brown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada.

12. MAIDEN NAME OF MOTHER Davy.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant Mrs. W. J. Swartz.

(Address) Newport, Ore.

15. Filed 1-18-, 1929 Paula McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 16th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 -, 1929, to Jan 16, 1929
that I last saw her alive on Jan 14, 1929
and that death occurred, on the date stated above, at 1:16 P.M.

The CAUSE OF DEATH* was as follows:

Senile gangrene of feet and legs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility and arteriosclerosis (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Taylor, M. D.

1/17/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	1/18/29 19

20. Undertaker Wm. McBratney | Address Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED FEB 7 1929

DO NOT WRITE IN THIS SPACE

State File No. 64329

PLACE OF DEATH

County of Ada

City of Boise Ida

Registration District No. 2

Primary Registration District No. 10th St.

Local Registrar's No. 14

(No. 415 N. 4th St.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME no name - is a monstrosity - Baby Radford.

(a) Residence. No. 415 N 4th St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	—

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Jan. 4th 1929

7. AGE	Years	Months	Days	If LESS than 1 day, 14 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Boise Ida

PARENTS

10. NAME OF FATHER Edgar D. Radford

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ida May Redford

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant John Booth

(Address) Boise Ida.

15. Filed 1-7-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 4th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 4th, 1929, to Jan. 4th, 1929

that I last saw him alive on Jan. 4th, 1929

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

convulsions - from hour of birth until death at intervals of about 30 minutes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) congenital malformation

(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. Booth M. D.

Jan. 5th, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
County Cemetery	1/7/29
20. Undertaker W. M. McBratney	Address Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64330

PLACE OF DEATH

County of Ada

City of Boise

RECEIVED FEB 7 1929

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 12

(No. St. Alphonsus Hospital

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Phillips Onederra

(a) Residence. No. 1 Mile East Garfield School Ada Co near Bim
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Dec. 30-1928

7. AGE Years Months Days 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Alphonsus Hos.

PARENTS

10. NAME OF FATHER Domingo Onederra

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spain

12. MAIDEN NAME OF MOTHER Josefa Arriola

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spain

14. Informant

(Address)

15. Filed 11-7-29 Mr Domingo Onederra P. L. McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1928, to Jan 3, 1929

that I last saw him alive on 1. 3. 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Cerebral accident accompanied c̄ prolonged & difficult labor & hydramnios (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Falk & Fuendeling M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. John's Cemetery — Date of Burial 1/4 1929

20. Undertaker Schreiber & McCann — Address Boise

Falks.

Dr. Pettengill

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64331

PLACE OF DEATH
County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 16
(No. 2005 N. 15th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Alice Louisa Edgley.

(a) Residence. No. 2005 N. 15th Street. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm. H. Edgley.

6. DATE OF BIRTH (month, day and year) Jan. 20th 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	11	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lestershire, England.

PARENTS

10. NAME OF FATHER Thomas L. Cox.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Hannah Harris.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Wm. H. Edgley.
(Address) Boise, Idaho.

15. Filed 1-2-, 1929 Paula McBoneed
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/1, 1928 to Jan 1, 1929 that I last saw her alive on Dec 31, 1928 and that death occurred, on the date stated above, at 5:05 P.M.

The CAUSE OF DEATH* was as follows:

Old Uremia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible], M. D.
1/2/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pocatello, Idaho. Date of Burial 19
Mt. View Cemetery.
20. Undertaker Wm. McBratney. Address Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 64332

RECEIVED FEB 7 1929

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

2. FULL NAME Edward T. Jordyn

(a) Residence. No. 519 Pierce Street St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower,

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 8 1853

7. AGE: Years 75 | Months 10 | Days 24 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Maine.

PARENTS

10. NAME OF FATHER: Elisha Jordan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maine.
12. MAIDEN NAME OF MOTHER: Sarah Jordan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Maine

14. Informant: Mrs Lucia Taylor
(Address) 519 Pierce Street Boise Idaho

15. Filed 1-4-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1928, to January, 1929
that I last saw him alive on Jan 1, 1928
and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:
Hemiplegia
(duration) yrs. mos. 20 ds.
CONTRIBUTORY (Secondary) Senility
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Harold W Stone, M. D.
1/3, 1929 (Address) 317 Eastman Bldg Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa Idaho. | Date of Burial: June 4 1928
20. Undertaker: Summers & Reis | Address: Boise Idaho

A. B. Boone

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64333

PLACE OF DEATH
RECEIVED FEB 7 1929
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 18
(No. St Lukes Hospital.
If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Henry Arnold
(a) Residence. No. Wilder Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec 30, 1928
7. AGE: Years | Months | Days: 6 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Boise Idaho

PARENTS
10. NAME OF FATHER: Frederick A. M. Arnold
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Emily M. Trostle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: F. A. M. Arnold
(Address) Wilder Idaho R 1 0 # 1
15. Filed 1-5-, 1929 Paula M. Bowers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 4 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1928, to Jan 4, 1929
that I last saw him alive on Jan 4, 1929
and that death occurred, on the date stated above, at 6 A m.
The CAUSE OF DEATH* was as follows:
Pyloric Stenosis
Congenital
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) C. V. Bosch M. D.
Jan 4, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Jan. 5 1929
20. Undertaker: Summers & Krebs — Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Trimmed

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64334

PLACE OF DEATH
County of Ada
City of Boise FEB 7 1929

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 19
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eliza Reynolds Davidson
(a) Residence. No. 1609 Warm Springs Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Davidson
6. DATE OF BIRTH (month, day and year): April 25-1872
7. AGE Years: 56 Months: 8 Days: 8 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Penn

PARENTS
10. NAME OF FATHER: William E. Reynolds
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Mary Henry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn.

14. Informant: Robert Davidson
(Address) 1609 W.S. 9 Boise Idaho
15. Filed 1-5-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 3 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1929, to Jan 3, 1929
that I last saw her alive on Jan 2, 1929
and that death occurred, on the date stated above, at 7 03 a m.
The CAUSE OF DEATH* was as follows:
Rheumatic heart disease (inactive) c̄ mitral stenosis. Auricular fibrillation.
(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) Congestive type of heart failure
(duration) yrs. mos. 21 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Phys. Exam
(Signed) Falk & Fuendeling M. D.
Jan 4, 1929 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Jan 5 1928
20. Undertaker: Summers & Krebs
Address: Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Dr. Braxton

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64335

PLACE OF DEATH
RE FEB 7 1929

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 20
(No. 508 South 15th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John L. Wagner.

(a) Residence. No. 508 South 15th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 6th 1850

7. AGE Years	Months	Days	If LESS than 1 day, ~~hours or~~ min.
68	I	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs. J. L. Wagner.
(Address) Boise, Idaho.

15. Filed 1-8-, 1929 Paula McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 5th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23, 1928, to Jan 5, 1929
that I last saw h alive on 19
and that death occurred, on the date stated above, at 2:45 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Colon
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Emaciation
(duration) yrs. 1 mos. 12 ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. M. Braxton, M. D.
1/7/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	1/8/29 19
20. Undertaker Wm. McBratney.	Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64336

PLACE OF DEATH

County of Ada FEB 7 1929
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 21

2. FULL NAME Wayne Albert Gibbens

(a) Residence. No. ... St. Riverside, Canyon Co.
(Usual place of abode) (If nonresident give city or town and state)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 2 - 1925

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	7	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Riverside, Ida.

PARENTS

10. NAME OF FATHER Everett Gibbens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Neb.
12. MAIDEN NAME OF MOTHER Gladys Mutch
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wis

14. Informant Everett Gibbens.
(Address) Huston Ida. R. # 1

15. Filed 1-7-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-3-, 1929, to 1-5, 1929
that I last saw h— alive on 1-5, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Meningitis.
Pneumococcus.
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Caldwell
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Spinal fluid
(Signed) T. W. Allred M. D.
1-6, 1929 (Address) Baker

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Caldwell, Ida.	1/7 1929
20. Undertaker	Address
Schreiber & McCann	Boise, Ida.

Absence

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Lanbaugh

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64337

PLACE OF DEATH
County of Ada
City of Boise

RECEIVED FEB 7 1929

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 22
(No. St. Luke's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joanne Swanson
(a) Residence. No. 542 So 5th Payette Ida St. Payette Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 1, 1922

7. AGE Years 7 Months 9 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Payette Ida

PARENTS
10. NAME OF FATHER Boyd Swanson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Marathon Iowa
12. MAIDEN NAME OF MOTHER Cecil Dixon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rankin Ill.

14. Informant Boyd Swanson
(Address) 542 So 5th Payette Ida

15. Filed 1-28-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 26 (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-30-28, 19 to 1-26-, 1929
that I last saw her alive on 1-26-, 1929
and that death occurred, on the date stated above, at 5:20 a.m.
The CAUSE OF DEATH* was as follows:
Purpura Hemorrhagica
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Double Mastoiditis
(duration) yrs. mos. 27 ds.

18. Where was disease contracted if not at place of death? Payette Idaho
Did an operation precede death? yes Date of Jan 17 & 22 1929
Was there an autopsy? no
What test confirmed diagnosis? Surgery + Mining
(Signed) Ernest E. Lanbaugh, M. D.
1/26-, 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Payette Idaho. Date of Burial Jan 27 1929
20. Undertaker Summers & Kirby Address Boise Ida

6

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64338

PLACE OF DEATH
County of Ada.
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

2. FULL NAME Marie A. Smith

(a) Residence. No. 419 S. 13 St.
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug-10-1852

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	5	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Paris France

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Mrs Vincent Parani
(Address) 419 S. 13 St Boise Idaho

15. Filed 1-12-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to Jan 11, 1929
that I last saw her alive on Jan 11, 1929
and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Oedema
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Ada County
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. W. Brashear, M. D.
Jan 12, 1929 (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Jan 12 1929

20. Undertaker Summers & Kreb Address Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64339

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 24
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Daniel Carey

(a) Residence. No. Boise Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 6-1871

7. AGE	Years	Months	Days	If LESS than 1 day,
	57	9	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Newville Ind.

PARENTS

10. NAME OF FATHER John Carey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Humberger
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Geo. N. Carey
(Address) 610 So 14th St Boise Ida

15. Filed 1-15-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 12 19 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29, 1928, to Jan 12, 1929
that I last saw him alive on Jan 12, 1929
and that death occurred, on the date stated above, at 3 a.m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Usual

(Signed) [illegible], M. D.
1 14, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Catholic Cemetery	1/15 1929

20. Undertaker Schroeder & McCann Address Boise Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64340

PLACE OF DEATH FEB 7 1929
County of Ada
City of Boise
Registration District No. 1004
Primary Registration District No.
Local Registrar's No. 25
(No. St Alphonsus Hospital.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME R. Wayne Christison
(a) Residence. No. 1309 Denver St.
(Usual place of abode)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced — HUSBAND of (or WIFE of): Dale Christison
6. DATE OF BIRTH (month, day and year): Sept-8-1906
7. AGE — Years: 22 — Months: 11 — Days: 5 — If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Service Station
(b) General nature of industry, business, or establishment in which employed (or employer): Operator
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Kansas

PARENTS
10. NAME OF FATHER: Charles J. Christison
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Maggie Cox
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Mrs Helen L Christison
(Address) 1309 Denver St Boise Idaho
15. Filed 1-14-1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 14 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 27, to 1/13, 1929
that I last saw h[illegible] alive on 1/12 1929
and that death occurred, on the date stated above, at 1.30 P m.
The CAUSE OF DEATH* was as follows:
T.B. of Pharynx + Larynx + mesenteric + Glands.
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary): None
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) A J Coad, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Jan 15 1929
20. Undertaker: Summers & Krebs. — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 7 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64341

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 26

1015 (No.) Resseguie Street.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Catherine Hall.

(a) Residence. No. 1015 Resseguie St.
(Usual place of abode)
Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Medford Hall.

6. DATE OF BIRTH (month, day and year) October 7th 1852

7. AGE Years	Months	Days	If LESS than 1 day, ——— hours or ——— min.
76	3	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bullitt Co. Ky.

PARENTS

10. NAME OF FATHER David Brooks.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.
12. MAIDEN NAME OF MOTHER Don't Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland.

14. Informant Thomas Hall.
(Address) 1014 Pueblo St. Boise, Ida.

15. Filed 1-15-, 1929 Paula M Bowers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 13th 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929 to Jan 13, 1929
that I last saw her alive on Jan 13, 1929
and that death occurred, on the date stated above, at 7:20 P.M. m.
The CAUSE OF DEATH* was as follows: Influenza and Senility

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs Symptoms
(Signed) PP Fredrick, M. D.
1/14/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	1/15/29 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 7 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64342

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 27

(No. 1304 Denver St.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Dew Shields

(a) Residence. No. 1304 Denver St St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Julia Shields.

6. DATE OF BIRTH (month, day and year) March 7th 1869

7. AGE	Years	Months	Days	If LESS than 1 day, ... hours ... min.
	59	10	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bond County, Illionis

PARENTS

10. NAME OF FATHER Thomas H. Shields.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bond Co. Illinois.

12. MAIDEN NAME OF MOTHER Frances A. Renfro.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Alton, Ill.

14. Informant Mrs. T. D. Shields.

(Address) 1304 Denver St.

15. Filed Jan 15 1929 Laula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jany (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1928, to Jan 15, 1929

that I last saw h.m alive on Jany 15, 1929

and that death occurred, on the date stated above, at 4.10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate Gland.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) anaemia (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Dont know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) C. S. Allen, M. D.

1/15, 1929 (Address) 305-306 McCarty Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hill Canyon Cemetery, Caldwell	1/16/29
Undertaker Wm. McBratney.	Address Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64343

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 28

2. FULL NAME Andrew Christian Sunton
(a) Residence. No. 1307 Main St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 2, 1852

7. AGE: Years 77, Months 11, Days 20. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Denmark

PARENTS

10. NAME OF FATHER: Hans C. Sunton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Christiana Christianson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Mrs E. A. Kemp
(Address) 2620 Main St Boise

15. Filed Jan 25, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 22 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1929, to Jan 22, 1929
that I last saw him alive on Jan 22, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Rheumatic heart disease (inactive) c̄ mitral stenosis & auricular fibrillation
(duration) 20 yrs. mos. ds.
CONTRIBUTORY (Secondary) Congestive type of heart failure (duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phys. Ex.
(Signed) Falk & Friedeling
Jan 23 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill
Date of Burial: 19

20. Undertaker: Schreiber & McCann
Address: Boise, Ida

Brayton & Stewart

RECEIVED FEB 7 1929

PLACE OF DEATH

County of Ada.

City of Boise.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64344

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 29

(No. St. Lukes Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Lloyd Hickerson.

(a) Residence. No. 29th & Gavin Street. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ----------

6. DATE OF BIRTH (month, day and year) April 26th 1916.

7. AGE: Years 12 | Months 9 | Days 2 | If LESS than 1 day, ---------- hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: In school.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Boise, Idaho.

PARENTS

10. NAME OF FATHER: Oscar D. Hickerson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Mattie Dabbs.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn.

14. Informant: Oscar D. Hickerson.

(Address): Boise, Idaho. R. #3

15. Filed 1-28-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 28th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1929 to Jan 28th, 1929 that I last saw him alive on Jan 28, 1929 and that death occurred, on the date stated above, at 2:39 A.M.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction due to Diverticulitis (Meckels)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Toxaemia & Shock.

(duration) yrs. mos. 5 hrs.

18. Where was disease contracted if not at place of death? His home

Did an operation precede death? Yes Date of Jan 27, 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. N. Brayton, M. D.

1/28/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. | Date of Burial: 1/29/29 19

20. Undertaker: Wm. McBratney. | Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED FEB 7 1929

DO NOT WRITE IN THIS SPACE

State File No. 64345

Local Registrar's No. 30

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Frances Goodwin

(a) Residence. No. 1516 No. 15th St. Boise, Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of M. N. Goodwin

6. DATE OF BIRTH (month, day and year) Dec. 4 1855

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73	1	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mt. Pleasant, Iowa

PARENTS

10. NAME OF FATHER William Burdge

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York, N.Y.

12. MAIDEN NAME OF MOTHER Mary Chandler

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Robert L. Stone

(Address) 1516 No. 15th St. Boise, Idaho

15. Filed 1-19-, 1929 Paula M. Bouard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1929, to Jan 16, 1929

that I last saw her alive on Jan 16 - 1929, 19.....

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tonsilitis

(duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) O N Parker, M. D.

Jan 18, 1929 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pioneer Cemetery	1 20 1929

20. Undertaker Schreiber & McCann Address Boise, Ida

10-27-28.

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64346

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 31

(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Lavina Nyblom.

(a) Residence. No. 2104 N. 20th street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eric Nyblom.

6. DATE OF BIRTH (month, day and year) Dec. 12th 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	1	7	----------

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Elkheart, Ind.

PARENTS

10. NAME OF FATHER Levi Smith.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Elizabeth McDowell.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Elkheart, Ind.

14. Informant Mrs. Carrie Brassey.

(Address) Boise. Idaho.

15. Filed 1-22-, 1929 Paula M'Donald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 19th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-27-, 1928, to , 19

that I last saw her alive on 1/19/29, 19

and that death occurred, on the date stated above, at 8:25 P M m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis and Acute Affliation.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) (?) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Ernest E Lawhead M. D.

1/21/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	1/22/29 19

20. Undertaker Wm. McBratney. Address Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Dr Lowe

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64347

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus)
Local Registrar's No. 32
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Kenneth Stinson

(a) Residence. No. 2504 Fairview Ave Boise
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 23-1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Boise Ida

PARENTS

10. NAME OF FATHER Elmer C Stinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Harley Ida
12. MAIDEN NAME OF MOTHER Rachael Knight
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Boise Ida

14. Informant Elmer C. Stinson
(Address) 2504 Fairview Ave. Boise Ida

15. Filed 1-25-, 1929 Linda McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1929 to Jan. 24, 1929
that I last saw him alive on Jan. 23, 1929
and that death occurred, on the date stated above, at 9-50 a m.
The CAUSE OF DEATH* was as follows:
Premature Birth
In labor from 1-30 a m to 5-10 a m.
(duration) — yrs. — mos. 1 ds.
CONTRIBUTORY (Secondary) None known
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Charles R. Lowe, M. D.
Jan. 25, 1929 (Address) R. 215 1st Nat Bank Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	1/25 1929
20. Undertaker Schreiber & McCann	Address Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64348

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No.)
Local Registrar's No. 33

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rachel Elizabeth McDonough

(a) Residence. No. 1800 N. 19 St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

R

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 18-1917

7. AGE: Years 11 | Months 6 | Days 9 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wyoming

PARENTS

10. NAME OF FATHER: Thomas W. McDonough
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Calif
12. MAIDEN NAME OF MOTHER: Lovisa W. Oosterhout
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Thomas W. McDonough
(Address) 1800 N. 19 St. Boise Idaho

15. Filed 1-29-1929 Laula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
I attended by physician 19
that I last saw h alive on 19
and that death occurred, on the date stated above, at 4:00 a.m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? History.
(Signed) L. F. West, M. D.
1-28, 1929 (Address) 413 Eastman Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: Jan 30 1929

20. Undertaker: Summers & Krebs | Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64349

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 34
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martin Dixon Fleming

(a) Residence. No. 828 Brumbach St.
(Usual place of abode)
Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 20, 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	77	4	7	hrs. or min.

8. OCCUPATION OF DECEASED.
(a) Trade, profession, or particular kind of work Retired Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Madison Wis.

PARENTS

10. NAME OF FATHER George Fleming
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Ann Hugh
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Laurette McGowan
(Address) 317½ W 8th St

15. Filed 1-29-, 19 29 Laura M. Duncan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 25th or 26th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ , 19 , to , 19 ; ~~that I last saw him~~ alive on , 19 ; ~~and that~~ death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Found Dead in Bed.
Natural Cause.
Had been in poor health
for several months
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility
No Inquest held.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) W McBratney Coroner, M. D.
1/28/29, 19 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 1/29 1929

20. Undertaker: Schreiber & McCann — Address: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, P should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64350

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 35

2. FULL NAME Dorothy Baldwin
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of — A. F. Baldwin
6. DATE OF BIRTH (month, day and year) June 1905
7. AGE: 23 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....
9. BIRTHPLACE (city or town) (State or country) Placerville Cal
PARENTS
10. NAME OF FATHER .....
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Placerville
12. MAIDEN NAME OF MOTHER .....
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....
14. Informant Sr. M Pegeo
(Address) Boise
15. Filed 1-29-, 1929 Paula McDonald Registrar
Braxton

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 26 1929
Jan. 26 (Month) Saturday (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to Jan 26, 1929
that I last saw her alive on Jan 26, 1929
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows: Tertiary Syphilis
..... (duration) 4 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Hepatic Cirrhosis
..... (duration) ..... yrs. 6 mos. 26 ds.
18. Where was disease contracted if not at place of death? California
Did an operation precede death? Yes Date of Dec 23rd 1928
Was there an autopsy? No
What test confirmed diagnosis? Wasserman and Lipping
(Signed) J. H. Braxton M. D.
Jan 28, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Johns Cem. | Date of Burial 19
20. Undertaker: Schreiber & McCann | Address: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64351

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 36
(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Mary H. Mathers
(a) Residence. No. 115 West State St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Grant D. Mathers
6. DATE OF BIRTH (month, day and year) Feb. 14-1876
7. AGE 52 Years 11 Months 13 Days If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER David Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Hannah Thomas
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant Caroline Mathers
(Address) 115 West State
15. Filed 1-29, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 27 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1928, to Jan 27, 1929
that I last saw her alive on Jan 27, 1929
and that death occurred, on the date stated above, at ___ m.
The CAUSE OF DEATH* was as follows:
Shock following thigh Amputation for femoral Thrombosis
(duration) ___ yrs. ___ mos. ___ ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) ___ yrs. ___ mos. ___ ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of 1/25/29
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptom
(Signed) Fred A. Tillinghast, M. D.
1/28, 1929 (Address) Boise Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. John's Cemetery — Date of Burial 19
20. Undertaker Schreiber & McCann — Address Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64352

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1904
(No. 807 E Washington)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 37

2. FULL NAME Mrs. Catherine F. Veelman
(a) Residence. No. 807 E Washington St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 35 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Herman Veelman

6. DATE OF BIRTH (month, day and year) 24 March 1864

7. AGE Years 64 Months 10 Days 3 If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lansing, Mich

PARENTS
10. NAME OF FATHER Mr. Burkret ~~Jan~~
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Not attainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant John Herman Veelman
(Address) Boise Idaho

15. Filed 1-31-, 1929 Paula McDonnell Registrar
Brock

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 27½ (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25½ 1929 to Jan 27½ 1929
that I last saw her alive on Jan 26½ 1929
and that death occurred, on the date stated above, at 1:30 P.m.
The CAUSE OF DEATH* was as follows:
Hemorrhage-cerebral
complete paralysis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) High blood pressure
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature] M. D.
Jan 29, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial 1/31 1929

20. Undertaker Schreiber & McCann
Address Boise, Ida

Dr. Budge

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64353

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 38

PLACE OF DEATH

County of Ada.

City of Boise.

(No. St. Alphonsus Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Florence Josephine Meyers.

(a) Residence. No. 1402 N. 24th Street. St.

(Usual place of abode)

Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of William T. Meyers.

6. DATE OF BIRTH (month, day and year) Oct. 17th 1904

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	3	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cora, Wyo.

PARENTS

10. NAME OF FATHER Aaron Fravis Lozier.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Catherine Rema.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Neb.

14. Informant Mrs. A. F. Lozier.

(Address) Hollister, Idaho.

15. Filed 2-1-, 1929 Paula M. Donael Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 31st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Jan 31, 1929

that I last saw h- alive on Jan 31, 1929

and that death occurred, on the date stated above, at 11:55 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis Foverish

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Jan 4 1929

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Agnes Bilder & Dr., M. D.

2/1/29 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain Home, Idaho. Date of Burial: 2/3/29 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Pattengers.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64354

RECEIVED FEB 7 1929

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 39

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martha Catherine Webster

(a) Residence. No. 2141 N. 15 St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 15. 1849

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	10	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER Goodman.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Mrs. George B. Miller
(Address) 2141 N 15 St Boise Idaho

15. Filed 1-30-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1928, to Jan 29, 1929
that I last saw her alive on Jan 28, 1929
and that death occurred, on the date stated above, at 1.05 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis
Senility

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms

(Signed) Fred A. Pettengers, M. D.
1/30, 1929 (Address) Boise Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Feb 1 1929
20. Undertaker	Address
Summers & Trebs	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Dr. Laubaugh.

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64355

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 7

Primary Registration District No. 1004

Local Registrar's No. 40

(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas B. Bay.

(a) Residence. No. Notus, Idaho. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 2 Wks. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) January 27th 1849

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	0	4	----------

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER David Bay.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Anna Newman.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant J. G. Watkins.

(Address) Parma, Idaho.

15. Filed 2-1-, 1929 Laura McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 31st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-14-, 1929, to 1-31-29, 19
that I last saw h-- alive on 1-31-29, 19
and that death occurred, on the date stated above, at 10:30P.M.
The CAUSE OF DEATH* was as follows:

Senile hypostrophy

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis with hyper-tension. Arteriosclerosis.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? (?)

Did an operation precede death? yes Date of 1/26/29.

Was there an autopsy? - no.

What test confirmed diagnosis? Surgery

(Signed) Ernest E. Laubaugh M.D.

2/1/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: 2/3/29 19

20. Undertaker: Wm. McBratney. — Address: Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 2 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64359

County of Ada.

City of Boise.

Registration District No. 9-10

Primary Registration District No. 9-10

Local Registrar's No. 1

(No. ½ Mile North of Star, Idaho.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Wesley Shaffer

(a) Residence. No. ½ Mile North of Star, Idaho. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) Nov. 5th 1862

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	1	28	----------

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell Co. Mo.

PARENTS

10. NAME OF FATHER Wm. H. A. Shaffer.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Harriett, Stoffle.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Lee Shaffer.

(Address) Star, Idaho.

15. Filed 1-4, 19 29 Orrin Jackson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 3rd 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ----------, 19--, to ----------, 19--

~~that I last saw him alive on~~ ----------, 19--

and that death occurred, on the date stated above, at About II A.M. m.

The CAUSE OF DEATH* was as follows:

Found dead in Public road near his home. Dropped dead while walking to town. Had ~~(duration)~~ ~~yrs.~~ ~~mos.~~ treated for heart trouble for a long time.

CONTRIBUTORY (Secondary) Acute Heart Disease (duration) 1 year mos. ds.

18. Where was disease contracted if not at place of death? Natural Cause. No Inquest

Did an operation precede death? ---------- Date of ----------

Was there an autopsy? ----------

What test confirmed diagnosis? ----------

(Signed) W. McBratney, Coroner ~~M.D.~~

1/3/29, 19-- (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Star Cemetery.	1/6/29 19

20. Undertaker Wm. McBratney. Address Boise, Ida

RECEIVED FEB 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 84

DO NOT WRITE IN THIS SPACE
State File No. 64381
Local Registrar's No. 144

PLACE OF DEATH
County of Cannon
City of Mt. Cammon
Registration District No.
Primary Registration District No. 2161
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Rachel Dora Romrell

(a) Residence. No. Mt. Cammon Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 14 yrs. 8 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) April 26, 1914

7 AGE: Years 14 | Months 8 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Mt. Cammon Ida

PARENTS
10 NAME OF FATHER: George Henry Romrell
11 BIRTHPLACE OF FATHER (city or town) (State or country): Lakestown Utah
12 MAIDEN NAME OF MOTHER: Martha Althea Lewis
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bingham City Utah

14 Informant: Geo Henry Romrell by C.A. Rich
(Address): Mt. Cammon Idaho

15 Filed Jan 31, 1929 Mrs. G. G. Fitz
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 19 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1929, to Jan 19, 1929, that I last saw her alive on Jan 18, 1929, and that death occurred, on the date stated above, at 8:22 a. m.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
..... (duration) ..... yrs. ..... mos. 9 ds.
CONTRIBUTORY (Secondary) Influenza
..... (duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis? Examination
(Signed) C.A. Rich, M. D.
Jan 19, 1929 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64382

PLACE OF DEATH
County of Bannock Registration District No. 84
City of Lava Hot Springs Primary Registration District No. 216
(No. .....)
Local Registrar's No. 143
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME None given. Death occured too early.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan 4, 1929.

7 AGE: Years | Months | Days | If LESS than 1 day, ... hrs. or 15 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Lava Hot Springs Idaho

PARENTS

10 NAME OF FATHER Robert Ray Bloxham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Downey Idaho

12 MAIDEN NAME OF MOTHER Zetta Josephine Avery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lava Hot Springs Ida

14 Informant Ray Bloxham
(Address) Lava Hot Spgs. Ida.

15 Filed Jan 31, 1929 Mrs. G. G. Fet
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 4 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Birth Jan 4 1929 to Jan 4, 1929,
that I last saw h~~e~~ alive on Jan 4, 1929,
and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:
Premature Delivery
6th month gestation
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Toxemia of pregnancy
on mother (duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) C. A. Rich, M. D.
1-4, 1929 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64413

PLACE OF DEATH
County of Bear Lake
City of Paris.

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Everett Henry Fuchs

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Baby

6. DATE OF BIRTH (month, day and year): Jan 10, 1929.

7. AGE: Years | Months | Days: 8 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Paris Idaho

PARENTS
10. NAME OF FATHER: Henry Fuchs.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Paris Idaho
12. MAIDEN NAME OF MOTHER: Ella Mechanz
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bloomington Idaho

14. Informant: Henry Franch
(Address): Paris Idaho

15. Filed 1-31, 1929 Mrs J S Stevenson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929 to Jan 18, 1929
that I last saw ~~him~~ alive on Jan 18 1929
and that death occurred, on the date stated above, at 4:20 a.m.
The CAUSE OF DEATH* was as follows:
Congenital Atelectasis.
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No Organic weakness & inability to
What test confirmed diagnosis? Clinical symptoms & Course
(Signed) Clarence H. Rich M.D.
Jan 18, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Paris Idaho — Date of Burial: Jan. 20th 1929
20. Undertaker: D. C. Rich — Address: Paris

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED FEB 6 1929

CERTIFICATE OF DEATH. 64414

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah

City of Tekoa

Registration District No.

Primary Registration District No. 31

(No. ..... St.)

File No. 6

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reymond Allen Baxter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Dec (Month) 5 (Day) 1911 (Year)

7. AGE 17 Yrs. 1 Mos. 26 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Labour

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Benewah Co

10. NAME OF FATHER Sam Baxter

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Pearl Logan

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Baxter

(Address) Tekoa Wa

15.

Filed Jan. 31 1929 John Post Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1929, to Jan 30 1929, that I last saw him alive on Jan 26 1929, and that death occured on the date stated above, at 9:00 M.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia (left lower lobe)

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) C B Cline M. D.

Jan 30 1929 (Address) Tekoa Wa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Farmington Wash

DATE OF BURIAL 191

20. UNDERTAKER C. L. Schullerud

ADDRESS Tekoa

SYMS - YORK CO., PTRS. & BORS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 6 1929

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

64415

1 PLACE OF DEATH
County Benewah State Idaho Registered No. 4
Township ..... or Village ..... or
City De Smet No. ..... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ethel Mary Edith Paul

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: 7
4 COLOR OR RACE: Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): July 29, 1921

7 AGE: Years 7 | Months 5 | Days 24 | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d'alene
(State or country) Reserve Idaho

PARENTS
10 NAME OF FATHER: Alex Paul
11 BIRTHPLACE OF FATHER (city or town) Coeur d'alene
(State or country) Reserve Idaho
12 MAIDEN NAME OF MOTHER: Isabell Moses
13 BIRTHPLACE OF MOTHER (city or town) Stevens Co
(State or country) Wash

14 Informant: Alex Paul
(Address) Plummer, Idaho

15 Filed Jan. 24, 1929 John Post REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 2[illegible] 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1929, to Jan 22, 1929, that I last saw her alive on Jan 18, 1929, and that death occurred, on the date stated above, at 10 P.m.

The CAUSE OF DEATH* was as follows:
Meningitis Tubercular

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? Clinical
(Signed) J. A. Nelson, M. D.
1/23 1929 (Address) Dickson

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Desmet, Ida
DATE OF BURIAL: Jan. 25 1929

20 UNDERTAKER: C. L. Schulerud
ADDRESS: Tekoa, Wash

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

RECEIVED FEB 5 1929

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

64416

1 PLACE OF DEATH

County Bennewah State Idaho Registered No. 3

Township Desmet or Village or

City No. , St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harold Ignatius Perry

(a) Residence. No. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 27, 1928

7 AGE Years Months Days 17 If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d'alene (State or country) Reservation Ida

PARENTS

10 NAME OF FATHER Edward Perry

11 BIRTHPLACE OF FATHER (city or town) Pendleton (State or country) Oregon

12 MAIDEN NAME OF MOTHER Josephine Smith

13 BIRTHPLACE OF MOTHER (city or town) Coeur d'alene (State or country) Reservation, Ida

14 Informant Dominick Timothy (Address) Tensed, Idaho

15 Filed Jan. 14, 1929 John Post REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1929

17 I HEREBY CERTIFY, that I attended deceased from Jan 12, 1929, to Jan 13, 1929, that I last saw him alive on Jan 13, 1929, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Bron Chopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) J. A. Nelson, M. D.

(Address) Teskon, Wn.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Desmet, Idaho

DATE OF BURIAL Jan. 15 1929

20 UNDERTAKER Albert Payne

ADDRESS Desmet, Idaho

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—269 d
V. S. No. 98

RECEIVED FEB 6 1929

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
64417 2 Registered No.

1 PLACE OF DEATH
County Benewah State Idaho
Township ____ or Village ____ or
City Tensed, No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Regina Falcon

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	Indian	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of Phillip Falcon

6 DATE OF BIRTH (month, day, and year) August 4, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
20	20	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho

PARENTS

10 NAME OF FATHER Wm Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Nez Perce Reservation

12 MAIDEN NAME OF MOTHER Mary Wildshoe

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Wash.

14 Informant Mrs. Phillip Falcon
(Address) DeSmet, Idaho

15 Filed Jan. 12, 1929 John Post REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1929, to Jan 11, 1929, that I last saw h[illegible] alive on Jan 10, 1929, and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) Miscarriage

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. Nelson M. D.

1/11, 1929 (Address) DeSmet

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
DeSmet, Idaho	Jan. 14 1929
20 UNDERTAKER	ADDRESS

PRINT UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 6 1929

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

64418

1 PLACE OF DEATH
County Benewah State Idaho Registered No. 1
Township ..... or Village ..... or
City Tensed, Idaho No. ..... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Phillip Falcon
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M
4 COLOR OR RACE Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 8-29

7 AGE Years Months Days If LESS than 1 day, 15 hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Benewah
(State or country)

PARENTS
10 NAME OF FATHER Phillip Falcon
11 BIRTHPLACE OF FATHER (city or town) Mont
(State or country)
12 MAIDEN NAME OF MOTHER Regina Smith
13 BIRTHPLACE OF MOTHER (city or town) Coeur d'Alene Reserve
(State or country)

14 Informant John Falcon Sr.
(Address) DeSmet

15 Filed Jan 9, 1929 John Post
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1929, to Jan 9, 1929
that I last saw him alive on Jan 5, 1929
and that death occurred, on the date stated above, at 59 m.
The CAUSE OF DEATH* was as follows:
Premature birth
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? — Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. A. Nelson, M. D.
1/9, 1929 (Address) Tensed

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DeSmet, Idaho
DATE OF BURIAL Jan. 9 1929

20 UNDERTAKER John Falcon Sr.
ADDRESS DeSmet Idaho

...OR BINDING

...s ould be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 64419

Local Registrar's No. 5

PLACE OF DEATH

County of Benewah

City of De Smet

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Marie Ursule Joseph Piell Kalispel

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Indian

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Piell Kalispel

6 DATE OF BIRTH (month, day and year) July 13, 1867

7 AGE: Years 61 | Months 6 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Coeur d'Alene Reserve

PARENTS

10 NAME OF FATHER Joseph Kaumlegui

11 BIRTHPLACE OF FATHER (city or town) (State or country) Coeur d'Alene Reserve

12 MAIDEN NAME OF MOTHER Juliana Leopold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Coeur d'Alene Reserve

14 Informant Piell Kalispel

(Address) Plummer, Idaho

15 Filed Jan. 27, 1929 John Post Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. (Month) 25 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Jan 20, 1929, that I last saw her alive on Jan 20, 1929, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows: Flu - Septic Infection

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Stomach

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Spokane

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C B Cline, M. D.

Feb 1929 (Address) Spokane

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: De Smet, Idaho | Date of Burial 19

20. Undertaker | Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64420

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

2. FULL NAME Loral Rowbury

(a) Residence. No. Jamestown Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE Years 18 Months 9 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) General Labor
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Moreland Ida

PARENTS
10. NAME OF FATHER Erick Rowbury
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Ada Vest
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant H. L. Bolansky
(Address)

15. Filed Jan 5, 1929 Mrs Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929, to Jan 4, 1929
that I last saw him alive on Jan 4 1929
and that death occurred, on the date stated above, at 5:30 a.m.
The CAUSE OF DEATH* was as follows:
Acute Myocarditis of
..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Splenic
Origin (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of ✓
Was there an autopsy? Yes
What test confirmed diagnosis? Observation
(Signed) F. E. Roberts, M. D.
Jan 4 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal City Cemetery Shelley Idaho
Date of Burial Jan 6th 1929.

20. Undertaker Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64421

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
(No.)
Local Registrar's No. 2

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna Andreason

(a) Residence. No. Near Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: C. C. Andreason

6. DATE OF BIRTH (month, day and year): Aug. 30 - 1840

7. AGE: Years 88 | Months 4 | Days 5 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Denmark

PARENTS

10. NAME OF FATHER: Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Christian Andreason
(Address) Shelley Idaho

15. Filed Jan 5 1929 McCaleb E Eaton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1929, to Jan 4, 1929, that I last saw her alive on Jan 4, 1929, and that death occurred, on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) 15 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Exam

(Signed) W. H. Egbert M. D.
Jan 5, 1929 (Address) Shelley Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Monroe, Utah — Date of Burial: Jan 8 1929

20. Undertaker: Jack A. Ward — Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64422

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 3

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leon Misslen

(a) Residence. No. 408 South University St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 4 1844

7. AGE: Years 84 | Months 1 | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lorain, France

PARENTS

10. NAME OF FATHER: Antoine Misslen

11. BIRTHPLACE OF FATHER (city or town) (State or Country): France

12. MAIDEN NAME OF MOTHER: Anne Marie Archel

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): France

14. Informant: Mrs. Paul DeVriendt
(Address) 408 So Univ

15. Filed Jan 4, 1929 Mrs Walter A Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1928, to January 4, 1929 that I last saw him alive on January 4, 1929 and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. M. Mitchell, M. D.

Jan 4, 1929 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery Blackfoot

Date of Burial: Jan 7 19

20. Undertaker: E. J. Kirk

Address: Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64423

PLACE OF DEATH

County of Bingham

City of Pingree

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 4

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Cartes

(a) Residence. No. Pingree Ida R1 #1 St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 6 yrs. \ mos. \ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of A. E. Cartes

6. DATE OF BIRTH (month, day and year) Dec 29, 1875

7. AGE Years 53 Months — Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Greenville Utah

PARENTS

10. NAME OF FATHER David Williams

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales

12. MAIDEN NAME OF MOTHER Margaret Reese

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant A E Carter

(Address) Pingree R1

15. Filed Jan 8, 1929 Mrs Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1928 to Jan 6, 1929

that I last saw her alive on Jan 3, 1929

and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Dropsy (Cardiac)

(duration) \ yrs. 1 mos. \ ds.

CONTRIBUTORY (Secondary) Influenza

(duration) \ yrs. \ mos. 10 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W W Beck, M. D.

1/8, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Riverside Thomas — Date of Burial Jan 9 1929

20. Undertaker E J Peck — Address Blackfoot

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 64424

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007 2194
(No. ~~[illegible]~~)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 5

2. FULL NAME Robert Sidney Ashton

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred — yrs. 11 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day and year) Feb 18, 1928

7 AGE — Years — Months 10 Days 18 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Blackfoot Idaho

PARENTS
10 NAME OF FATHER J. L. Ashton
11 BIRTHPLACE OF FATHER (city or town) (State or country) Utah
12 MAIDEN NAME OF MOTHER Nona Judd
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah

14 Informant Jedidiah L. Ashton
(Address) Blackfoot, Ida R4 #1

15 Filed Jan 7, 1929 Mrs Walter E Fature
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 6 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1929, to Jan 6, 1929, that I last saw him alive on Jan 6, 1929, and that death occurred, on the date stated above, at 12:50 p.m.

The CAUSE OF DEATH* was as follows:
Acute Ileo Colitis
..... (duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) W W Beck, M. D.
1/7, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Groundwater cemetery
Date of Burial: Jan 8 1929

20. Undertaker: E J Peck
Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64425

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 6

(No. SOUTHERN IDAHO MENTAL HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME CLARA HODGSON

(a) Residence. No. ..... St. IDAHO FALLS-Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Don't know~~ Moroni Hodgson

6. DATE OF BIRTH (month, day and year)

7. AGE: 67 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Salt Lake City, Utah

PARENTS

10. NAME OF FATHER: Henry Skidmore,

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Philadelphia

12. MAIDEN NAME OF MOTHER: Sarah M Elliott

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Philadelphia-Penna

14. Informant: Edna Deininger Att.
(Address) Southern Idaho Mental Hospital

15. Filed Jan 9, 1929 Mrs Clarence E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: JANUARY 8TH-1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4th 1928, 19 ..., to Jan 7th 1929, 19 ...
that I last saw her alive on Jan 7th 1929, 19 ...
and that death occurred, on the date stated above, at 5:15 P m.
The CAUSE OF DEATH* was as follows:

PARALYSIS OF INSANE

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none

(Signed) Geo. Williams, M. D.
Jan. 8th, 1929 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Peton | Date of Burial: Jan 11th 1929

20. Undertaker: W. M. Hansen | Address: St. Anthony Ida

RECEIVED FEB 8 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Woodville

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ..... , ... St.)

File No. 64426

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Theda Rae Gifford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Sept (Month) 1 (Day) 1927 (Year)

7. AGE: 1 Yrs. 4 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Babe

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo Alvin Gifford

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Florence E. Chaffin

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Denzel L Gifford

(Address) Shelley R.F.D. # 3.

15. Filed Jan 11 1929 Mrs Walter E Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-15 1928, to 1-9-1929 that I last saw her alive on 1-5-1929 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Malnutrition

..... (Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary) Erysipelas

..... (Duration) ..... yrs. ..... mos. 15 ds.

(Signed) Edwin Cutler M. D.

1-11-1929 (Address) Shelley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodville, Idaho

DATE OF BURIAL: 1-11-1929

20. UNDERTAKER: None

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYME-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64427

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 8194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Wilson Ellis
(a) Residence. ~~No.~~ Moreland Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sofronia Ellis
6. DATE OF BIRTH (month, day and year) Dec 7 1870
7. AGE Years 58 Months 1 Days 3 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Logan Utah

PARENTS
10. NAME OF FATHER George Ellis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Jamiah Wiggate
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) africa

14. Informant Orvil W. Ellis
(Address) Moreland Idaho
15. Filed Jan 11, 1929 Mrs Charles E. Palmer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 10 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from January 1, 1929, to January 10, 1929
that I last saw h..... alive on ....., 19..
and that death occurred, on the date stated above, at 7 A. m.
The CAUSE OF DEATH* was as follows:
Influenza
..... (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H. A. Mitchell, M. D.
1/10, 1929 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Thomas Riverside
Date of Burial Jan 13 1929
20. Undertaker E J Kirk
Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 8 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 64428

Local Registrar's No. 9

1. PLACE OF DEATH

County of BINGHAM

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. Idaho Insane Asylum St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cora Etta Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: MARRIED (Write the word)

6. DATE OF BIRTH: Dec (Month) 22 (Day) 1879 (Year)

7. AGE: 49 Yrs. 0 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Springfield, Mo

10. NAME OF Father: Geo. Gerhart,

11. BIRTHPLACE OF FATHER (State or Country): Georgia

12. MAIDEN NAME OF MOTHER: Eliz. Couch,

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grace A. Clippinger

(Address) Idaho Insane Asylum

15. Filed Jan 10 1929 Mrs Walter E. Palmer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 10th 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ investigated deceased ~~from~~ ~~Jan 5th 1929~~ to Jan 10th 1929, that I last saw her ~~alive~~ dead on Jan 10th 1929, and that death occurred on the date stated above, at 10:15 AM M.

The CAUSE OF DEATH* was as follows:

suicide by hanging

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Acute mania depressive

(Duration) ..... yrs. 6 mos. 15 ds.

(Signed) W. E. Patrick Coroner M. D.

10/1 1929 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 5 days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? Boise, Idaho

Former or usual residence: Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho

DATE OF BURIAL 19

20. UNDERTAKER: E. J. Peck

ADDRESS: Blackfoot Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64429

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 10

SOUTHERN IDAHO INSANE ASYLUM
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME J. F. WYLIE

(a) Residence. No. ..... St. Caldwell, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 16 yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tazwell, Tenn.

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Alfred G. Mercer Att.
(Address) Blackfoot, Idaho.

15. Filed Jan 12, 1929 Mrs Coalter E. Tate Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 11th-1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st, 1928, 19..... to Jan. 11-1929, 19.....
that I last saw him alive on Jan. 11-1929, 19.....
and that death occurred, on the date stated above, at 9:10A m.
The CAUSE OF DEATH* was as follows:

Epilepsy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo. Williams, M. D.
Jan. 11-, 1929 (Address) Blackfoot, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Asylum Cemetery	Jan. 12, 1929
20. Undertaker	Address
J. A. Bailey	Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED FEB 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

File No. 64430

County of Bingham

City of Shelley (No. ....., ... St.)

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Betty Jane Hyslop

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec 27 (Month) (Day) 1928 (Year)

7. AGE: ..... Yrs. ..... Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Shelley Ida. Bingham

10. NAME OF FATHER: George Hyslop

11. BIRTHPLACE OF FATHER (State or Country): Idaho Falls Ida.

12. MAIDEN NAME OF MOTHER: Vara Canter

13. BIRTHPLACE OF MOTHER (State or Country): Ammon Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Hyslop

(Address) Shelley Ida

15. Filed Jan 15 1929 W. Wallace Ed Lalone Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 14 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1929 to Jan 14 1929, that I last saw her alive on Jan 13 1929, and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. V. Peterson M. D.

Jan 15 1929 (Address) Shelley Ida

*State the *Disease Causing Death*; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shelley, Idaho — DATE OF BURIAL: Jan 15 1929

20. UNDERTAKER: Clifford Hayes — ADDRESS: Idaho Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64431

PLACE OF DEATH
County of Bingham
City of Moreland

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

2. FULL NAME Emmeline Amelia Hatch
(a) Residence. No. Moreland Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Abram Hatch

6. DATE OF BIRTH (month, day and year): Feb-27-1863

7. AGE: Years 65 | Months 10 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS
10. NAME OF FATHER: Wm. M. Miles
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Martha J Curtis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill

14. Informant: Abram Hatch
(Address): Moreland Ida

15. Filed Jan 18, 1929 Wm Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan - 15 - 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1929, to Jan 15, 1929
that I last saw her alive on Jan 14 1929
and that death occurred, on the date stated above, at 9.55 a. m.
The CAUSE OF DEATH* was as follows:
Influenza
..... (duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary): Nephritis
..... (duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? place of death
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? History & physical examination
(Signed) W. K. Eagan Do, M. D.
Jan 17, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moreland Cem
Date of Burial: 1-18-1929

20. Undertaker: Modern Mortuary
Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64432

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

2. FULL NAME Gray Jones
(a) Residence. No. East Shelley St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 21 1927

7. AGE Years 1 Months 6. Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley Ida

PARENTS
10. NAME OF FATHER Lew C Jones.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.
12. MAIDEN NAME OF MOTHER Louise Clow.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Phyllis Jones.
(Address) Shelley Ida.

15. Filed Jan 18, 1929 Mrs Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1929, to Jan 17, 1929
that I last saw him alive on ....., 19..
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis
..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) none
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical Exam
(Signed) J. R. Egbert, M. D.
Jan. 17, 1929 (Address) Shelley Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley Ida
Date of Burial Jan 18 1929

20. Undertaker Cliff C Hayes
Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 8 1929

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

(No. Southern Idaho Insane Asylum)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64433

Local Registrar's No. 14

2. FULL NAME EDGAR C COX

(a) Residence. No. ..... St. KUNA IDAHO
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	DIVORCED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 4- 1855

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	5	13	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER William Cox,

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER Helen Chizim,

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mich.

14. Informant John Grobatig Att.
(Address) Blackfoot, Idaho.

15. Filed Jan 30 1929 Mc Cullen Coleman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 17th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1928, to Jan 17th 1929
that I last saw h im alive on Jan 16th 1929
and that death occurred, on the date stated above, at 6:45A m.

The CAUSE OF DEATH* was as follows:

Paralysis of insane

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Geo Williams, M. D.

Jan. 17th, 1929 (Address) Blackfoot Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Olympia Wash — Date of Burial 19

20. Undertaker E O Tuck — Address Blackfoot

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64434

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 18

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mildred Gene Stoddart

(a) Residence. No. Presto St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX f
4. COLOR OR RACE w
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Oct. 4 - 1928

7. AGE Years Months 3 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Salt Lake City

PARENTS
10. NAME OF FATHER William C. Stoddart
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho Falls Idaho
12. MAIDEN NAME OF MOTHER Mary Stoddard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant W. C. Stoddard
(Address) Firth Ada

15. Filed Jan 29, 1929 Mrs Walter E Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ investigated deceased ~~from~~ Jan 29, 1929, to ....., 19..., that I last saw her ~~alive on~~ dead Jan 29, 1929 and that death occurred, on the date stated above, at 10:15 m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Otitis Media - Sup.

..... (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) W. E. Patrie, M. D.
Jan 29, 1929 (Address) Health Officer

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Firth Cem. Date of Burial Jan. 30 1929

20. Undertaker W. C. Stoddard Address Shelley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64436

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194.
Local Registrar's No. 17
(No. South Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ben Amoureoux

(a) Residence. No. ..... St. Nampa, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: BROWN --
5. Single, Married, Widowed, or Divorced (write the word): SINGLE

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 62 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: --
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: --
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Ted Hayes Att.
(Address) Blackfoot, Idaho.

15. Filed Jan 30, 1929 Mrs Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 29th, 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18th 1929, 19 to Jan 29th 29, 19
that I last saw him alive on Jan 29th, 1929, 19
and that death occurred, on the date stated above, at 4:55 P m.
The CAUSE OF DEATH* was as follows:

Paralysis of insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
Jan 30th, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa Idaho | Date of Burial 19

20. Undertaker: E J Rush | Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 64445

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bingham
City of Aberdeen

Registration District No. 116
Primary Registration District No. 2195
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 20

2. FULL NAME Darold Leyshon

(a) Residence. No. Aberdeen, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct 1 1925

7 AGE: Years 4 | Months 4 | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Aberdeen, Ida

PARENTS

10 NAME OF FATHER Lorenzo Leyshon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Utah

12 MAIDEN NAME OF MOTHER Jenne May Warner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah

14 Informant Nephi Beck
(Address) Aberdeen, Ida

15 Filed 2/1, 1929 McMackinnon
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 31 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1929, to Jan. 31, 1929, that I last saw him alive on Jan. 31, 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral - Spinal meningitis
Epidemic type

..... (duration) ..... yrs. ..... mos. 19 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Laboratory - Spinal fluid
(Signed) M. C. McKinnon, M. D.
2/1, 1929 (Address) Aberdeen, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Aberdeen, Ida
Date of Burial: 2/2 1929

20. Undertaker: Friends
Address: Aberdeen

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64448

PLACE OF DEATH
County of Blaine
City of Ketchum

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

2. FULL NAME Robert Hugo Shroy.

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	X

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6. DATE OF BIRTH (month, day and year) June 5 - 1926

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	6	16	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED X
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Hamer Ida.
(State or country)

PARENTS

10. NAME OF FATHER Clemance Shroy
11. BIRTHPLACE OF FATHER (city or town) Piedmont Wyo.
(State or Country)
12. MAIDEN NAME OF MOTHER Clara Rohberg
13. BIRTHPLACE OF MOTHER (city or town) Rolling Wyo.
(State or Country)

14. Informant Clemance Shroy
(Address) Ketchum Ida

15. Filed 1 - 31, 1929 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1 - 20, 1929, to 1 - 21, 1929
that I last saw him alive on 1 - 21, 1929
and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows: Scalded - covering 2/3 body surface - accidentally fell into tub of boiling water.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Robert H. Wright - M. D.
1 - 22, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt Home Ida	Jan 24 1929
20. Undertaker	Address
Harris & Sons	Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64449

PLACE OF DEATH

County of Blaine
City of Picabo

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 2

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles H. Eden

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Nettie Eden

6. DATE OF BIRTH (month, day and year) Apr 14 - 1861

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	9	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Thomas Eden

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Iris Yonkin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs. Mabel Osborn
(Address) Boise Idaho.

15. Filed 1-31, 1929 Robert H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-1, 1928, to 1-21, 1929
that I last saw h~~im~~ alive on 1-18, 1929
and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Chronic endocarditis -
(duration) ..... yrs. 3 mos. ..... ds.
CONTRIBUTORY (Secondary) Nephritis
(duration) ..... yrs. 4 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Robert H. Wright M.D.
1-22, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Picabo Idaho	Jan 23 1929
20. Undertaker	**Address**
Harris & Amos	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Dr. Rec.

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64450

PLACE OF DEATH

County of Boundary
City of Dufort

Registration District No. 78
Primary Registration District No. 2152
Local Registrar's No.
(No. Dufort Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thelma Dora Taylor

(a) Residence. No. Dufort Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 12 1911

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Brady Montana

PARENTS

10. NAME OF FATHER Chas W Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Sarah Lambert
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Chas W Taylor
(Address) Dufort

15. Filed Jan 31, 1929 Sipha Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24, 19..., to Jan 24, 1929
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 10:15 A m.
The CAUSE OF DEATH* was as follows:
Septicaemia following
Tuberculosis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? Clinical

(Signed) J E Ross M. D.
6/20, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Westmond	Feb 2 1929
20. Undertaker: Tunnell Co	Address: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1929

PLACE OF DEATH

County of Bonner

City of Hope

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78

Primary Registration District No. 2155

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64451

Local Registrar's No.

2. FULL NAME Mary Soper Scott.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edgar A. Scott.

6. DATE OF BIRTH (month, day and year) June 14, 1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	71	7	12	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebraska City. Neb.

PARENTS

10. NAME OF FATHER William W. Soper

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boston Mass

12. MAIDEN NAME OF MOTHER Susan [redacted] Sites

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Providence R.I.

14. Informant Emma A Scott

(Address) Hope, Idaho.

15. Filed Jan 29, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1929 to Jan 26, 1929

that I last saw her alive on Jan 25, 1929

and that death occurred, on the date stated above, at 9.20 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Floyd C. Wendle M. D.

Jan 29, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane, Wash.	Jan. 1929

20. Undertaker L. E. Moon. Address Sandpoint, Ida.

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64452

PLACE OF DEATH
County of Bonner
City of Kootenai

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William John McRea

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 33 rs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced, HUSBAND of Julia McRea (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 6, 1872

7. AGE	Years	Months	Days	If LESS than 1 day,
	57	10	13	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Humbird Lumber Co.

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Dan McRea

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ontario, Canada.

12. MAIDEN NAME OF MOTHER Martha Noise

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pennsylvania

14. Informant Mrs Laird Eshorn
(Address) Moscow, Idaho.

15. Filed Jan 29, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 19th. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 12:30 p. m.

The CAUSE OF DEATH* was as follows:
Accidental Traumatism; crushed by rolling logs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. S. Moon Coroner M. D.
1/22/29, 19 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Jan. 24 1929
20. Undertaker: Moon Mortuary	Address: Sandpoint, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64453

PLACE OF DEATH

County of Bonner

City of Cabinet

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Nolan

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years 25 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) Ranch

(c) Name of employer J. C. Brooks

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant J.C.Brooks
(Address) Cabinet, Idaho.

15. Filed Jan 29, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 6th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Suicide by Firearms.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. A. Moon, Coroner.

Jan. 6th, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pinecrest Cemetery

Date of Burial JAN 9 1929

20. Undertaker MOON MORTUARY

Address Sandpoint, Ida.

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64454

Local Registrar's No.

PLACE OF DEATH

County of Bonner
City of Kootenai Ida
Registration District No. 78
Primary Registration District No. 2155
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harriet Matilda Graves

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alex Graves.

6. DATE OF BIRTH (month, day and year) Nov 12 1844

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	2	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10. NAME OF FATHER John Roe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Ben Graves
(Address) Kootenai Idaho.

15. Filed Jan 21, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:
1. Senility
2. Bronchitis, Chronic,
many
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. P. Jackson, M. D.
1-21-, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Jan 21 1929

20. Undertaker L. G. Moon Address Sandpoint Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64455

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jennie Sanborn Molyneux

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fred Murray Molyneux

6. DATE OF BIRTH (month, day and year) March 28th 1858

7. AGE	Years	Months	Days	If LESS than 1 day,
	70	9	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Concord
(State or country) New Hampshire

PARENTS

10. NAME OF FATHER John A. Sanborn

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) New Hampshire

12. MAIDEN NAME OF MOTHER Jennie Alberton Sanborn

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) New Hampshire

14. Informant Russell Murray Molyneux
(Address) Sandpoint, Idaho.

15. Filed Jan 20, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January (Month) 18th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 9, 1928, to Jan 18, 1929
that I last saw her alive on Jan 17, 1929
and that death occurred, on the date stated above, at 6.30 a m.
The CAUSE OF DEATH* was as follows:
Hypostatic Pneumonia
Acute

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [illegible] M. D.
1/19, 1929 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, [illegible]	Date of Burial
Spokane, Washington.	Jan. 20 1929
20. Undertaker	Address
Moon Mortuary	Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1929

PLACE OF DEATH

County of Bonner

City of Samuels (rural)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 16

Primary Registration District No. 2155

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64456

Local Registrar's No. .....

2. FULL NAME Reuben Dahlstrom

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 15-1915

7. AGE

Years	Months	Days	If LESS than 1 day,
13	6	1	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Burke
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Charles Dahlstrom

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Finland

12. MAIDEN NAME OF MOTHER Nina ——

13. BIRTHPLACE OF MOTHER (city or town) Crystal Falls
(State or Country) Mich.

14. Informant Nina Dahlstrom

(Address) Samuels.

15. Filed Jan 1 F, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9, 1929, to Jan 16, 1929
that I last saw him alive on Jan 7, 1929
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(duration) ..... yrs. ..... mos. 7 ~~10~~ ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Blood Test

(Signed) C E Alcorn M. D.

1-19, 1929 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pack River Cemetery	Jan. 19 1929
20. Undertaker L. G. Moon	Address Sandpoint, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THI

64457 State File No.

County of Bonner

City of Sagle (rural) Registration District No. 7C

Primary Registration District No. 2155

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Riley

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Riley

6. DATE OF BIRTH (month, day and year): March 8, 1847

7. AGE — Years: 81 — Months: 9 — Days: 29 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): New York

PARENTS

10. NAME OF FATHER: John Riley

11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary Casey

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Marey E Riley

(Address): Sagle RI

15. Filed Jan 8, 1929 Viola Allen Registrar

Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 7th (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not to attend, 19

that I last saw h alive on 19

and that death occurred, on the date stated above, at 12:30PM m.

The CAUSE OF DEATH* was as follows:

Arteria sclerosis

Senility

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Floyd G. Gentle M. D.

Jan. 9, 1929 (Address) Sandpoint Ida

County Physician

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: ~~Lakeview Cemetery~~ Spokane, Wash — Date of Burial: 1/10 29

20. Undertaker: Turnbull Co. — Address: Sandpoint

RECEIVED FEB 6 1929

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2155

File No. 64458

City of Clarksfork

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Rounsville

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH: April (Month) 1 (Day) 1889 (Year)

7. AGE: 39 yrs. 8 mos. 30 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Henry Freischmidt

11. BIRTHPLACE OF FATHER (State or Country): Berlin Germany

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F O Broady

(Address) Clark's Fork Idaho

15.

Filed Jan. 4 1929 Viola Allen Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1928, to Jan 2 1929, that I last saw her alive on Jan 2 1929, and that death occurred on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

..... (Duration) ..... yrs. ..... mos. 20 ds.

Contributory (Secondary) Pregnancy

..... (Duration) ..... yrs. 6 mos. 15 ds.

(Signed) F O Broady M. D.

Jan 3 1929 (Address) Clark's Fork, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rebecca Minnesota

DATE OF BURIAL: ..... 1929.

20. UNDERTAKER: R. E. Wessa

ADDRESS: Priest River, Idaho.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64459

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Garnett Thompson Hartman

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Inez Uren Hartman

6. DATE OF BIRTH (month, day and year) February 1, 1876

7. AGE	Years	Months	Days	If LESS than 1 day,
	52	11	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) Proprietor
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Homer, Illinois

PARENTS

10. NAME OF FATHER George A. Hartman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Sadie -------

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Inez Uren Hartman
(Address) Sandpoint, Idaho.

15. Filed 2 - 2, 1929 Floyd C. Wendle, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 31, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1929 to Jan 31, 1929
that I last saw him alive on Jan. 31, 1929
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Pneumonia, Lobar
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. 1 mos. 15 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. P. Stackhouse M. D.
Feb. 1, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Homer, Illinois	Feb. 3, 1929
20. Undertaker	Address
Moon Mortuary	Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64460

PLACE OF DEATH
County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
(No.)
Local Registrar's No. 1
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Homer Rogers

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Marie K. Rogers

6 DATE OF BIRTH (month, day and year) Oct. 22, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	46	2	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bridgewater S. D.

PARENTS

10 NAME OF FATHER Calvin Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Viola Wis.

12 MAIDEN NAME OF MOTHER Elizabeth Severson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Marie K. Rogers
(Address) Priest River, Idaho

15 Filed Jan. 3, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January (Month) 2, (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 15 1928, to Dec 30, 1928, that I last saw h... alive on Dec 30, 1928, and that death occurred, on the date stated above, at 1:00 p.m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach and peritonitis
(duration) one yrs. mos. ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Oct 15 1928
Was there an autopsy? No
What test confirmed diagnosis? Surgical signs
(Signed) P A Lower, M. D.
Jan 3, 1929 (Address) Priest River, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Woodmen Cemetery — Date of Burial: Jan. 5, 1929

20. Undertaker: Moon Mortuary — Address: Priest River

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64461

PLACE OF DEATH
County of Bonner
City of Vay.

Registration District No. 85
Primary Registration District No. 2185
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

2. FULL NAME Viola J. McKusick.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Freeman McKusick.

6. DATE OF BIRTH (month, day and year) Aug 24, 1844

7. AGE Years 84 Months 4 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Maine.

PARENTS

10. NAME OF FATHER Jackson Corson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine.
12. MAIDEN NAME OF MOTHER Phoeba Barrows
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maine.

14. Informant F. E. McKusick
(Address) Vay, Idaho.

15. Filed Jan. 3, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 2, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 8:00 p. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
Arterio-Sclerosis
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Floyd G. Wendle M. D.
Jan. 3, 1929 (Address) Sandpoint, Ida
County Physician

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Seneacquoteen Cemetery
Date of Burial Jan 4, 1929

20. Undertaker L. L. Moon
Address Sandpoint, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 8 1929

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 7-6

(No. 1523 - 10th St. South)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64486

Local Registrar's No. 2

2. FULL NAME Velva Irene Richardson

(a) Residence. No. 1523 - 10th Str So. St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Aug 2 - 1915.

7. AGE	Years	Months	Days	If LESS than 1 day,
	13	5	2	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work school girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rolla Kan.

PARENTS

10. NAME OF FATHER R.C. Richardson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) W. V.

12. MAIDEN NAME OF MOTHER Cola Wiley.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) W. V.

14. Informant R.C. Richardson

(Address) Nampa, Idaho.

15. Filed 1-- 6, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1928, to Jan. 4, 1929

that I last saw h[illegible] alive on Jan. 4, 1929

and that death occurred, on the date stated above, at 12:10 P. m.

The CAUSE OF DEATH* was as follows:

Flu.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Trouble

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm E. Young M. D.

Jan. 5, 1929 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	1-6 1929
20. Undertaker	Address
Mrs. Nina M. Talley	Nampa, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED FEB 8 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 64487

Local Registrar's No. 3

1. PLACE OF DEATH

County of Ada

City of Kuna

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Abe B. Plum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Mar. (Month) 26 (Day) 1862 (Year)

7. AGE: 66 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): Self

9. BIRTHPLACE (State or Country): Penn

10. NAME OF Father: unknown

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. A. Plum

(Address) Kuna R#2

15.

Filed 1-10 1929 [signature]

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1929, to 19, that I last saw him alive on Jan 6 1929, and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Coronary thrombus

(Duration) yrs. mos. ds. (5-20 minutes)

Contributory (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) Geo. R. Proctor M. D.

19 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill, Boise Ida

DATE OF BURIAL: 1929

20. UNDERTAKER: Fred K Robinson

ADDRESS: Nampa Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Proctor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 6448

Local Registrar's No. 4

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No.

Primary Registration District No.

(No. Mercy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Emily O. Carver

(a) Residence. No. 316 – 18th Ave S. St.

(Usual place of abode)

Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of L. G. Carver

6. DATE OF BIRTH (month, day and year) April 7th 1878

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	9	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Kansa

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER W. N. Hall

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgia

12. MAIDEN NAME OF MOTHER Elizajane Martin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) no. Carolina

14. Informant Mr. E. L. Carver

(Address) Nampa, Idaho

15. Filed 1–9, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 8– (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1928, to Jan. 8–, 1929

that I last saw her alive on Jan. 8–, 1929

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? –

Did an operation precede death? Yes Date of 1-7-29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel A Swayne, M. D.

1–8–, 1929 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	1-10 1929
20. Undertaker	Address
Mrs. Nina M. Talley	Nampa, Ida.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED FEB 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. ..... St.)

File No. 64489

Registered No. 5

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edna Hutteball

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 29 (Day) 1912 (Year)

7. AGE: 16 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Baker Oregon

10. NAME OF FATHER: K M Hutteball

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Hilda G Clark

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [signature]

(Address) Nampa Idaho

15. Filed 1-13 1929

Bertha Conway
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 20 1928, to Jany 9 1929, that I last saw her alive on Jany 9th 1929, and that death occurred on the date stated above, at 12:40 M.

The CAUSE OF DEATH* was as follows:

Status Epileptiques

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

1-9 1929 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 9 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Fred K P Benson

DATE OF BURIAL: 1-10 1929

20. UNDERTAKER: Burial Boise

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19 REC FEB 8 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 64490

Local Registrar's No. 6

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 2006

(No. ..... St.)

2. FULL NAME James B Newman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word)

6. DATE OF BIRTH: May (Month) 3 (Day) 1875 (Year)

7. AGE: 53 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Andrews N. C.

10. NAME OF Father: John Newman

11. BIRTHPLACE OF FATHER (State or Country): Andrews No C.

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. B. Newman
(Address) Kuna R.1. Idaho

15. Filed 2-8 1929 Arthur Conway
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1928, to Jan 2 1929, that I last saw him alive on Jan 1 1929, and that death occurred on the date stated above, at 3 M.

The CAUSE OF DEATH* was as follows:

Cancer Bladder 6 mo.

(Duration) ..... yrs. 6 mos. ..... ds.

Contributory (Secondary) Myocarditis Hyp prostate

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Horace P Belknap M. D.

1929 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlown Cem

DATE OF BURIAL: 1-3 1928

20. UNDERTAKER: Fred R Robinson

ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

H.P.B.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64492

PLACE OF DEATH

County of Canyon

City of north of Nampa

Registration District No. 7

Primary Registration District No. 2006

(No. north of Nampa)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Luella Ferguson

(a) Residence. No. north of Nampa St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of D. G. Ferguson

6. DATE OF BIRTH (month, day and year) Oct. 9th

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
60	3	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Walla Walla Washington

PARENTS

10. NAME OF FATHER S. R. Maxson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Mary E. Paul

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mr. D. G. Ferguson

(Address) Nampa, Idaho

15. Filed 1-19, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 17th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1928, to Jan, 1929

that I last saw her alive on Jan. 10, 1929

and that death occurred, on the date stated above, at 5:15 a. m.

The CAUSE OF DEATH* was as follows: Cancer of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? none

(Signed) W. C. Notts, M. D.

Jan. 17, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa

Date of Burial: 1-20 1929

20. Undertaker: Mrs. Nina M. Talley

Address: Nampa, Ida.

REGISTERED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64493

PLACE OF DEATH

County of Canyon
City of 3 mi So. Bowmont
Registration District No. 7
Primary Registration District No. 2006
(No. 3 miles so. Bowmont)
Local Registrar's No. 9
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary A. McDonald

(a) Residence. No. 3 miles so. Bowmont St.
(Usual place of abode)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of H. M. McDonald

6. DATE OF BIRTH (month, day and year) July 26th 1848

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	5	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cincinnati Ohio

PARENTS

10. NAME OF FATHER Henry Remley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penna.
12. MAIDEN NAME OF MOTHER — Fowler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Mrs. Edward Utt
(Address) Everett, Washington

15. Filed 1-19, 1929 Estella Inman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 19th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw her alive on September, 1928
and that death occurred, on the date stated above, at 1:45 a.m.
The CAUSE OF DEATH* was as follows:

Carcinoma of the face
about two years
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Geo. R Proctor M. D.
1-19-, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Melba - Idaho	1-20 1929
20. Undertaker	Address
Mrs Nina M Talley	Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED FEB 8 1929

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 956

(No. Mercy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64494

Local Registrar's No. 16

2. FULL NAME Hazel Alma Parker

(a) Residence. No. 419 - 15th Ave. no. St.

(Usual place of abode)

Length of residence in city or town where death occurred. 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chester R. Parker

6. DATE OF BIRTH (month, day and year) Dec. 21st - 1910

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	18		27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Northville S. South Dakota

PARENTS

10. NAME OF FATHER Elmer S. Van Houten

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Northville So. Dakota

12. MAIDEN NAME OF MOTHER Edna M. Perry

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Northville So. Dakota

14. Informant Mrs. E. S. Van Houten

(Address)

15. Filed 1-31, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 18th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1929 to Jan 18, 1929

that I last saw h[illegible] alive on Jan 18, 1929

and that death occurred, on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH* was as follows:

Toxemia of pregnancy

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chorea

(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of Jan 15

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V E Peplinger M. D.

1-21-, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn - Nampa	1-21 1929
20. Undertaker	Address
Mrs. Nina M. Talley	Nampa, Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED FEB 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7

Primary Registration District No. 2114

File No. 64495

Registered No. 7

1. PLACE OF DEATH

County of Canyon

City of Nampa RR No 3 (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nelson Gray Cleek

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 24 (Day) 1857 (Year)

7. AGE: 71 Yrs. 8 Mos. 30 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Jackson Co. Mo.

10. NAME OF FATHER: Adam J Cleek

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Dorothy Pfost

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs E. Gann

(Address) Nampa Ida.

15.

Filed 1-25 1929 Bertha Brown Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1929, to Jan 15 1929 that I last saw h[illegible] alive on Jan 22 1929 and that death occurred on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

..... (Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Myocarditis

..... (Duration) 4 yrs. ..... mos. ..... ds.

(Signed) J. H. Murray M. D.

1/23 1929 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 8 mos. ..... days. Lived here since 1884 In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? /

Former or usual residence /

19. PLACE OF BURIAL OR REMOVAL: Star Ida. DATE OF BURIAL: 1/25 1929

20. UNDERTAKER: Wm Talley. ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED FEB 8 1929

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64497

Registration District No. 7

Primary Registration District No. 2

Local Registrar's No. 13

(No. Mercy Hospital)

(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Mrs. Lydia McDole

(a) Residence. No. 6 miles so. Nampa St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm McDole

6. DATE OF BIRTH (month, day and year): Jan. 26th 1862

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
67	0	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Syracuse Ohio

PARENTS

10. NAME OF FATHER: Henry Thomas

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Margaret Driver

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14. Informant: Mrs August Fitchner

(Address): Nampa, Idaho

15. Filed 1-30, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 30th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1929, to Jan 30, 1929

that I last saw her alive on Jan 30, 1929

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary): Myocarditis. Acute dilitation (duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Swayne M. D.

1-30, 1929 (Address) Nampa, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa

Date of Burial: 2-1 1929

20. Undertaker: Mrs. Nina M. Tadley

Address: Nampa, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED FEB 8 1929

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St.)

State File No. 64498
Local Registrar's No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice V. Williams

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6. DATE OF BIRTH: Feb. (Month) 15 (Day) 1860 (Year)

7. AGE: 68 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Texas

10. NAME OF Father: William H. Wamble

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Wardlow

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Otto Blackaby
(Address) Homedale Ore

15.
Filed 1-31 19 [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-25 1929 to 1-27 1929 that I last saw h[illegible] alive on 1-27 1929 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. Horton M. D.
1-27 1929 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview Cem
DATE OF BURIAL: 1-30 1929

20. UNDERTAKER: Fred P. Thomason
ADDRESS: Nampa Ida

Horton

FORM V. S. No. 5-25 M. 1-19.

RECEIVED FEB 8 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 64499

Local Registrar's No. 5

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. [illegible]

(No. ..... St.)

2. FULL NAME Lotice Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Mar (Month) 28 (Day) 1888 (Year)

7. AGE: 39 Yrs. ..... Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF Father: James W. Staples

11. BIRTHPLACE OF FATHER (State or Country): Virg.

12. MAIDEN NAME OF MOTHER: Lucy Fritfull

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. S. Williams
(Address) 603-16 A. South, Nampa Ida

15. Filed 1-17 1929 [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1929 to Jan 15 1929 that I last saw her alive on Jan - 15 1929, and that death occurred on the date stated above, at 7.45 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) Myocarditis

..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) J. C. Horton M. D.

1-16 1929 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fred K Robinson

DATE OF BURIAL: 1-17 1929

20. UNDERTAKER: Kohlerlown Cem

ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

4

FORM V. S. No. 5-25 M. 1-19.

RECEIVED FEB 8 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 64500

Local Registrar's No. 6

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Colgacarta

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single
6. DATE OF BIRTH: Sept (Month) 9 (Day) 1911 (Year)
7. AGE: 17 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): John J Calgacorta
10. NAME OF Father: Spain
11. BIRTHPLACE OF FATHER (State or Country): Lorenza Gabica
12. MAIDEN NAME OF MOTHER: Spain
13. BIRTHPLACE OF MOTHER (State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elena Gabica
(Address) Nampa Ida.
15.
Filed 1-5 1929 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1928 to Jan 3 1929, that I last saw her alive on Jan 3 1929, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. P. Ross M. D.
1-10 1929 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverview Cem. DATE OF BURIAL: 1-5 1929
20. UNDERTAKER: Fred A Johnson ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH FEB 8 1929

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1006

(No. ..... St.)

2. FULL NAME Mary Winney

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 64502

Local Registrar's No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widowed (Write the word)

6. DATE OF BIRTH: Oct (Month) 17 (Day) 1[illegible] (Year)

7. AGE: 77 Yrs. ..... Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer): (Retired)

9. BIRTHPLACE (State or Country): Butown Wis

10. NAME OF Father: Unknown

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ~~ABOVE~~ IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A. D. Irish
(Address) 1123 - 14 Ave. Nampa Ida

15. Filed 2 - 8 1929 Bertha Conway
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1928 to Jan 19, 1929 that I last saw her alive on Jan 19, 1929 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo R Proctor M. D.

19 ..... (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Sibley Iowa

DATE OF BURIAL: 1 - 20 1929

20. UNDERTAKER: Fred K Robinson

ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64503

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 5
Primary Registration District No. 2007
Local Registrar's No. 1
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Harrison Smith

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 30-1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	8	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Texas Co.
(State or country) Missouri

PARENTS

10. NAME OF FATHER Spencer Smith
11. BIRTHPLACE OF FATHER (city or town) Not Known.
(State or Country)
12. MAIDEN NAME OF MOTHER Micky Slate
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Missouri

14. Informant Ina F. Smith
(Address) Hazelton Mont.

15. Filed Feb 1, 1929 Ruth Waldron Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1928, to Jan 7, 1928
that I last saw him alive on Jan 7, 1928
and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH* was as follows:

Influenza and Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) H. M. Mutchler M. D.
1-10, 1929 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parma	Jan 10 1929
20. Undertaker	Address
C. V. Peckham	Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64504

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 3
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name in [illegible] and number.)

Local Registrar's No. 2

2. FULL NAME Andrew Jackson Wymer
(a) Residence. No. Parma
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How [illegible] if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widower
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May-9-1847
7. AGE Years 81 Months 8 Days 7 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS
10. NAME OF FATHER Geo. Wymer.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Samantha C. Hulse
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois.

14. Informant Frank Wymer
(Address) Parma, Ida
15. Filed Feb 1, 1929 Luly Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. [illegible] DEATH Jan. 16 1929 (Month) (Day) (Year)
17. [illegible] CERTIFY, That I attended deceased from [illegible], 1929, to Jan 16, 1929
that I last saw him alive on Jan 14, 1929
and that death occurred, on the date stated above, at 9-58 m.
The CAUSE OF DEATH* was as follows:
Acute Nephritis
(duration) about yrs. 1 mos. — ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 20 yrs. — mos. — ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) W. E. Waldrop, M. D.
Jan. 20, 1929 (Address) Parma, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Parma Cem
Date of Burial: 1-21 1929
20. Undertaker: C. V. Peckham
Address: Caldwell Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64505

Registration District No. 9
Primary Registration District No. 1005
Local Registrar's No. 7

PLACE OF DEATH

County of Canyon
City of Caldwell
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Andrew Hall Hart

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 3-1845

7. AGE Years	Months	Days	If LESS than 1 day,
83	6	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter, Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Eaton Ohio.

PARENTS

10. NAME OF FATHER L. L. Hart
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Eton Ohio
12. MAIDEN NAME OF MOTHER Mary Fall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Eton Ohio

14. Informant E. Mar Hart.
(Address) Caldwell Ida Canyon Co. Ida

15. Filed 2-3-1929 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1920, to Jan 15 1929
that I last saw h alive on Jan 15 1929
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Y
Did an operation precede death? No Date of Y
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. H. Dudley, M. D.
2/4, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Feb 3 1929

20. Undertaker C. V. Peckham — Address Caldwell Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64506

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 6

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eldon John Stang

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 24 - 1919

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
9	4	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell Idaho
(State or country)

PARENTS

10. NAME OF FATHER John Stang

11. BIRTHPLACE OF FATHER (city or town) Minn.
(State or Country)

12. MAIDEN NAME OF MOTHER Bessie Allen

13. BIRTHPLACE OF MOTHER (city or town) Great Falls Mont.
(State or Country)

14. Informant John Stang.
(Address) Parma, Idaho

15. Filed 2-8-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30, 1929, to Jan 31, 1929
that I last saw him alive on Jan 30, 1929
and that death occurred, on the date stated above, at 3:30 a m.
The ~~CAUSE~~ OF DEATH* was as follows:
Tetanus infection from pitchfork wound on the foot.
(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? Yes Spinal fluid Exam.
What test confirmed diagnosis?
(Signed) H. M. Nitchke, M. D.
2-5, 1929 (Address) Parma Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Feb. 3 1929
20. Undertaker C. T. Peckham	Address Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64507

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 5
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Roscoe B. Randolph
(a) Residence. No. R F D St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mch 9 1887

7. AGE	Years	Months	Days	If LESS than 1 day,
	41	10	22	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Galena Kans

PARENTS

10. NAME OF FATHER Jackson F Randolph
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Martha Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Mrs R B Randolph
(Address) R F D Caldwell Idaho

15. Filed 2-4-, 1929 John S. Meyer - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 31-29 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at 11 A M m.

The CAUSE OF DEATH* was as follows:
Shotgun wound of head, Accidental probably. No eye witnesses.

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Paul L. Case M. D.
Feb, 3-29, 19.... (Address) Coroner, Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Feb 4-29 19

20. Undertaker	Address
Paul L. Case	Caldwell Idaho

FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64508

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 4
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Silas J. A. Allen
(a) Residence. No. Middleton St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 22-1845

7. AGE: 83 Years, 7 Months, 0 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired rancher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not known

PARENTS
10. NAME OF FATHER " "
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Clark Allen
(Address) Hailey Ida

15. Filed 1-25-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1929, to Jan 22, 1929
that I last saw him alive on Jan 22, 1929
and that death occurred, on the date stated above, at 3-30 a.m.
The CAUSE OF DEATH* was as follows: Myocarditis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Exposure to cold & lack of food for 2 days.
..... (duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
1-23, 1929 (Address) Caldwell Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Middleton Cem
Date of Burial: Jan. 25 1929

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 25 M. 1-19

FEB 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nea Middleton

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 2005

(No. ..... St.)

File No. 64509

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Eugene Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 10 (Day) 1928 (Year)

7. AGE: ..... Yrs. 5 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canyon County Idaho

10. NAME OF FATHER: William Norman Harris

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma

12. MAIDEN NAME OF MOTHER: Gladys Mae Ray

13. BIRTHPLACE OF MOTHER (State or Country): Vancouver B.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Haines

(Address) Caldwell Idaho

15. Filed 1-21- 1929

John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 17 1928, to Jany 18 1929, that I last saw him alive on Jany 18 1929 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Abscess Brain

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Abscess Ear

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C W Hall M. D.

1-18 1929 (Address) Star Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: Jan 21 1929

20. UNDERTAKER: Paul L Case

ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64510

PLACE OF DEATH
County of Canyon
City of Middleton

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 2

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bertha Johnine Middlekauff
(a) Residence. No. Middleton St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: C. D. Middlekauff

6. DATE OF BIRTH (month, day and year): Aug 24 1890

7. AGE: Years 38, Months 4, Days 21. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Monette Missouri

PARENTS
10. NAME OF FATHER: Benj F. Hunter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....
12. MAIDEN NAME OF MOTHER: Kanaflix
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant: C. H. Middlekauff
(Address): Middleton Ida

15. Filed 1-23-, 1929. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 9-45 P. m.
The CAUSE OF DEATH* was as follows:
Apoplexy
..... (duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [signature] M. D.
1/18, 1929 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: Jan. 23 1929

20. Undertaker: C. W. Peckham
Address: Caldwell, Ida

RECD FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64511

PLACE OF DEATH

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 1
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James alfred Mc Mullen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 23 1860

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	11	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Astoria
(State or country) Oregon

PARENTS

10. NAME OF FATHER John Mc Mullen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Minerva A. Bond
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs O. F. Olmsted
(Address) R F D #4 - Caldwell Ida

15. Filed 1-5-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24, 1928 to Jan 2, 1929
that I last saw him alive on Oct 24, 1928
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:

Apoplexy
(duration) ..... yrs. several mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) Herbert M. D.
1/3, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Jan 4th 1929
20. Undertaker C. V. Peckham	Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64512

PLACE OF DEATH
County of Caribou
City of Soda Springs Ida

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

2. FULL NAME Christopher Panting
(a) Residence. No. Soda Springs Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lina Panting

6. DATE OF BIRTH (month, day and year) Aug. 14-1850

7. AGE Years 77 Months 4 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Gloustershire, Eng.

PARENTS
10. NAME OF FATHER Chas Panting
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Crook
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Worthing C. Panting
(Address) Soda Springs Ida

15. Filed 1-10-, 1929 Dr Russell Sigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1928, to June 6, 1929
that I last saw him alive on June 4, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Influenza

..... (duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) 0

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? 0 Date of —
Was there an autopsy? 0
What test confirmed diagnosis? —
(Signed) Eric Kackley, M. D.
1-10-, 1929 (Address) Soda Spring Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida — Date of Burial 1-9- 1929

20. Undertaker C. D. Whiteman — Address Soda Springs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 64545

PLACE OF DEATH

County of Clearwater
City of Orofino

CERTIFICATE OF DEATH

Registration District No. 90
Primary Registration District No. 2168
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 1

2. FULL NAME Amelia Brisson

(a) Residence. No. 0106 - 29th St. St. Lewiston, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Fred Brisson

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 82 | Months ? | Days ? | If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10 NAME OF FATHER Peter Le Gree
11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada
12 MAIDEN NAME OF MOTHER Matilda Porquet
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wisconsin

14 Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15 Filed Jan 30, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 1 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from September 29, 1926, to January 1, 1929, that I last saw her alive on January 1, 1929, and that death occurred, on the date stated above, at 9 55 A. m.

The CAUSE OF DEATH* was as follows:
Chronic endocarditis - complicated by ~~endocard~~ influenza.
(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Senile psychosis
(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John Irvine McKelway, M. D.
January 1, 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: No. Idaho Sanitarium Cemetery
Date of Burial: Jan. 4 1929

20. Undertaker: F. A. Billberg - Hosp. Attdt.
Address: Orofino - Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64546

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2168

Local Registrar's No. 2

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Wells

(a) Residence. No. Wells Bench St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79		9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) Farming
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) B. C. Canada

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Fred Moores
(Address) Orofino

15. Filed Jan 31, 1929. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
12/31, 1928, to 1/1, 1929
that I last saw him alive on 12/31, 1928
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Flu - Pneumonia - Heart

(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Auto accident last fall
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) H. F. Robertson M. D.
1/2, 1928 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Orofino Cemetery & Standard — Date of Burial Jan 3 1929

20. Undertaker W. D. Pinson — Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 11 1929

PLACE OF DEATH

County of Clearwater

City of Orofino

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 7 6 8

DO NOT WRITE IN THIS SPACE

State File No. 64547

Local Registrar's No. 3

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William J. Tiemeyer

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Wm Tiemeyer

6. DATE OF BIRTH (month, day and year) Sep 15 1893

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	3	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ind

PARENTS

10. NAME OF FATHER William Tiemeyer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind

12. MAIDEN NAME OF MOTHER Mary Kopp

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind

14. Informant Mrs C. F. Witson

(Address) Peck Ida

15. Filed Jan 30, 1929. Ruth M. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19, 1928, to Jan 3, 1929, that I last saw ~~him~~ alive on Jan 3, 1929, and that death occurred, on the date stated above, at 10.30 PM

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? hotel-near Orofino

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) O M Husted, M. D.

Jan 3rd, 1929 (Address) Orofino Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	Jan 5 1929

20. Undertaker	Address
V. A. Shaw	Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 11 1929

PLACE OF DEATH

County of Clearwater

City of Orofino

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 2168

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 64548

Local Registrar's No. 4

2. FULL NAME George F. Howard

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) —

7. AGE: About 52 Years; Months ✓; Days ✓; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ✓

PARENTS

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant W. A. Shaw Coroner
(Address) Orofino Ida

15. Filed Jan 30, 1929 Dep W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 31, 1929, to Jan 4, 1929

that I last saw h..... alive on ....., 19....

and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Influenza, acute
(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Septicemia, acute
(duration) ..... yrs. ..... mos. 4 ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R. F. Hopkins, M. D.

2/1, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino Ida — Date of Burial: Jan 8 1929

20. Undertaker: W. A. Shaw — Address: Orofino

Public Health Adviser
Food and Drug Inspection
Bacteriological Laboratory
Chemical Laboratory
Sanitary Engineer
Bureau of Child Hygiene
Vital Statistics

DAVID BURRELL, Commissioner

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
Lava Hot Springs, Lava
Idaho Soldiers' Home, Boise
Northern Idaho Sanitarium, Orofino
State School & Colony, Nampa

H. C. BALDRIDGE, Governor

February 20, 1929.

RECEIVED FEB 25 1929

Dr. R. T. Hopkins,

Re: 64548

Orofino, Idaho.

Dear Doctor:

We are writing with reference to the death certificate of GEORGE T. HOWARD who died January 4th, 1929. Will you kindly advise whether he was

SINGLE, MARRIED, WIDOWED or DIVORCED?

You also state as the contributory cause of death:

"Septicemia, acute".

Will you kindly advise the cause of the Septicemia? Copies of our death certificates are sent to the Census Bureau at Washington and we are required to get all information in order that proper classification may be made as to the cause of death.

An addressed stamped envelope is enclosed for your convenience in making reply.

Respectfully yours,

C. K. Macey

C. K. MACEY
State Registrar.

ANSWER BELOW:

divorced. -
Septicemia was the result of a septic sore throat probably streptococcic accompanying influenza.

R. T. Hopkins

MAR 13 1961

RECEIVED FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64549

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 3168
(No. Northern Idaho Sanitarium)
Local Registrar's No. 5
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Sarah Carew

(a) Residence. No. ..... St. Viola - Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unascertained

6 DATE OF BIRTH (month, day and year) Unascertained

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Falls City Nebraska

PARENTS

10 NAME OF FATHER William Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER —— Ranier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15 Filed Jan 30, 1929 Dept. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
January (Month) 6 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to January 6, 1929, that I last saw her alive on January 5, 1929, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:
Malignant disease of face (epithelioma)
(duration) 3 yrs. + mos. + ds.
CONTRIBUTORY (Secondary) Paranoid condition
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted ✓ if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) John Irvine Mahaffey, M. D.
Jan. 6, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
No. Idaho Sanitarium Cemetery	Jan. 8 1929
20. Undertaker	Address
F. A. Dillberg, Hosp. Attat.	Orofino, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64550

Registration District No. 90
Primary Registration District No. 768
Local Registrar's No. 6

PLACE OF DEATH
County of Orofino
City of Clearwater /

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martin Kukka

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 49

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
(38) About 38			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fin

PARENTS
10. NAME OF FATHER /
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant W. A. Shaw Coroner
(Address) Orofino

15. Filed Jan 30, 1929. Jeff. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 9 (Month) 1929 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 11 G m.
The CAUSE OF DEATH* was as follows:

Suicidal by hanging self from a bridge with wire

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. A. Shaw Coroner, M. D.
1/9, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Jan 11 1929
20. Undertaker	Address
W. A. Shaw	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64551

PLACE OF DEATH

County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

2. FULL NAME Edward Louis Ball
(a) Residence. No. Greer - Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 69 | Months 1 | Days 21 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Shoe repairing cobbler
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer: himself

9. BIRTHPLACE (city or town) (State or country): Syracuse NY.

PARENTS

10. NAME OF FATHER: Francis D Ball
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Some where in U S.
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: William Ball
(Address) Pier Ida

15. Filed Jan 30, 1929, Deep W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~12~~ Jan. 9th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1929, to Jan 9th, 1929
that I last saw him alive on 1-9, 1929
and that death occurred, on the date stated above, at 1230 P.m.
The CAUSE OF DEATH* was as follows:
apoplexy = Haemorrhage in brain =
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): none unless
Hard work (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? his home
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? paralysis, double vision etc
(Signed) J. F. Robertson M. D.
1/11, 1927 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: [illegible] Date of Burial: Jan 11 1929
20. Undertaker: W. D. Pinson Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 11 1929

PLACE OF DEATH

County of Clearwater

City of Orofino

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 768

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64552

Local Registrar's No. 8

2. FULL NAME Amos Corbbett Bonaparte

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Red

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About Years 28 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ida

PARENTS

10. NAME OF FATHER: Amos Bonaparte

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Jane Corbbett

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ida

14. Informant: Mrs Jane Corbbette
(Address) Ahsahka

15. Filed Jan 30, 1929. Def N A Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 13 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to Jan 13, 1929

that I last saw him alive on Jan 13, 1929

and that death occurred, on the date stated above, at 9.30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Orofino Idaho

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) O M Husted, M. D.

Jan 3, 1929 (Address) Orofino Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ahsahka Ida

Date of Burial: Jan 5 19..

20. Undertaker: N A Shaw

Address: Orofino

RECEIVED FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64553

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

2. FULL NAME Anthone Lassley

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Lassley

6. DATE OF BIRTH (month, day and year): Mar 6 1867

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	10	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10. NAME OF FATHER: Frank Lassley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Frank Lassley
(Address): Orengemont Ida

15. Filed Jan 30, 1929. Def. V. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 14 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/23, 19 28, to 1/14, 19 29
that I last saw h[illegible] alive on Jan. 14, 19 29
and that death occurred, on the date stated above, at [illegible] a.m.
The CAUSE OF DEATH* was as follows:

Bronchitis, chronic
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Asthma, chronic
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) G. J. Hopkins, M. D.
1/1, 19 29 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Weasman Cemetery	Jan 15. 1929
20. Undertaker: V. A. Shaw	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64554

Local Registrar's No. 10

PLACE OF DEATH

County of Shoshone
City of Wallace

Registration District No. 90
Primary Registration District No. 1168
(No. Northern Idaho Sanitarium)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME L. V. Close

(a) Residence. No. ____ St. Wallace, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Deloss Close

6 DATE OF BIRTH (month, day and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	36	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Star Line, Wisconsin

PARENTS

10 NAME OF FATHER August Klever

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unascertained

12 MAIDEN NAME OF MOTHER Edith Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unascertained.

14 Informant Records: Northern Idaho Sanitarium
(Address) Wallace - Idaho

15 Filed Jan 30, 1929 Deff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
January (Month) 14 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to January 14, 1929, that I last saw her alive on January 13, 1929, and that death occurred, on the date stated above, at 12:15 A. m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Dementia praecox, hebe-phrenic type (duration) 10 yrs. + mos. + ds.

18 Where was disease contracted ✓ If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) John Irvine McKelvey, M. D.

January 14, 1929 (Address) Wallace, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
No. Idaho San. Cemetery.	Jan. 15 1929
20. Undertaker	Address
F. A. Billberg, Hosp. attat.	Wallace, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS: should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64556

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 768

(No. Northern Idaho Sanitarium)

Local Registrar's No. 12

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Moses C. Shugart

(a) Residence. No. ..... St. Whitebird, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Unascertained

7 AGE: Years 85 | Months ? | Days ? | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unascertained

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unascertained

12 MAIDEN NAME OF MOTHER: Unascertained

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unascertained.

14 Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15 Filed Jan 30, 1929 Dep. N. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January (Month) 19 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from February 17, 1928, to January 19, 1929, that I last saw him alive on January 19, 1929, and that death occurred, on the date stated above, at 9.50 A.m.

✓ The CAUSE OF DEATH* was as follows:
Exhaustion following accidental fracture of right femur, November 9, 1928.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Psychosis with cerebral arterio-sclerosis (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) John Irvine McKelvey, M. D.

January 19 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Orofino Ida

Date of Burial: Jan 23 1929

20. Undertaker: N. A. Shaw

Address: Orofino

Public Health Adviser
Food and Drug Inspection
Bacteriological Laboratory
Chemical Laboratory
Sanitary Engineer
Bureau of Child Hygiene
Vital Statistics

DAVID BURRELL, Commissioner

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
Lava Hot Springs, Lava
Idaho Soldiers' Home, Boise
Northern Idaho Sanitarium, Orofino
State School & Colony, Nampa

H. C. BALDRIDGE, Governor

February 20th, 1929.

RECEIVED FEB 25 1929
RECEIVED FEB 25 1929

Dr. John I. McKelway,

Orofino, Idaho. Re: 64556

Dear Doctor:

With reference to the death certificate of MOSES C. SHUGART who died at the Asylum on January 19th, 1929.

You gave as the cause of death: "Exhaustion following accidental fracture of right femur, November 9th, 1928."

Will you kindly advise WHAT KIND OF AN ACCIDENT was the primary cause of death. In cases of injuries or fractures, we are required to procure a statement as to the cause.

An addressed stamped envelope is enclosed for your convenience in making reply.

Respectfully yours,

C. K. Macey

C. K. Macey,
State Registrar.

ANSWER BELOW and return:

Patient, an arterio-sclerotic case, had an attack of Syncope, fell to the floor, fracturing right femur. Lt Bone had been fractured years before - 2x years prior to Commitment.

John Irvine McKelway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 11 1929

PLACE OF DEATH

County of Clearwater

City of Orofino

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 10

Primary Registration District No. N C 8

DO NOT WRITE IN THIS SPACE

State File No. 64557

Local Registrar's No. 13

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Wright

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Wright

6. DATE OF BIRTH (month, day and year) Sep 27 - 1877

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	3	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER William Wright

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind

12. MAIDEN NAME OF MOTHER May Gilserson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ina

14. Informant Clara Wright

(Address) Creer Ida

15. Filed Jan 30, 1929. W. A. Shaw Jr. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-29, 1928, to 1-20, 1929

that I last saw him alive on 1-20, 1929

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Influenza

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) W. F. Robinson M. D.

1-1, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gifford Ida	Jan 22 19
20. Undertaker	Address
W. A. Shaw	Orofino

RECEIVED FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64558

Local Registrar's No. 14

PLACE OF DEATH

County of Clearwater
City of Orofino
Registration District No. 20
Primary Registration District No. 2168
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME John Jones

(a) Residence. No. ..... St. Lewiston, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 0 yrs. 7 mos. 3 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6 DATE OF BIRTH (month, day and year) Unascertained

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	✓	✓	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Common laborer
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kansas City - Missouri

PARENTS

10 NAME OF FATHER William Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Dakota

12 MAIDEN NAME OF MOTHER Mary Thomasburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa

14 Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15 Filed Jan 30, 1929 [signature illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 20 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1928, to January 20, 1929, that I last saw him alive on January 19, 1929, and that death occurred, on the date stated above, at 5:10 A. m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Psychosis with psychopathic personality (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John Howe McKelvey, M. D.
January 20, 1929 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: No. Idaho San. Cemetery — Date of Burial: Jan. 22 1929

20 Undertaker: F. A. Billberg, Hosp. Mgr. — Address: Orofino, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 11 1929

PLACE OF DEATH

County of Clearwater

City of Weippe

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. N68

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64559

Local Registrar's No. 15

2. FULL NAME Albert David Whaley

(a) Residence. No. Weippe, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Irene Dinwiddie

6. DATE OF BIRTH (month, day and year)

7. AGE Years 77 Months 10 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wakeman New York

PARENTS

10. NAME OF FATHER David Whaley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Prudence Courser

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Mrs. Irene Whaley

(Address) Weippe Ida

15. Filed Jan 30, 1929 Def. Mr. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1929, to Jan 24, 1929 that I last saw him alive on Jan 19, 1929 and that death occurred, on the date stated above, at 2:05 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. 15 ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R. T. Hopkins, M. D.

1/24, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Weippe Ida — Date of Burial Jan 26 1929

20. Undertaker W D Pinson — Address Orofino

RECEIVED FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 64560

PLACE OF DEATH

County of Clearwater

City of Orofino

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 2168

(No. Northern Idaho Sanitarium)

Local Registrar's No. 16

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Rosa Presto -

(a) Residence. No. ..... St. Priest River, Idaho -
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? 30 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mike Presto

6 DATE OF BIRTH (month, day and year) July 2, 1872

7 AGE: Years 56 | Months 6 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER G. Ottobane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Borea Maria Rollero

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Records: Northern Idaho Sanitarium

(Address) Orofino, Idaho.

15 Filed Jan 30, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Janvary (Month) 26 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Janvary 12, 1929, to Janvary 26, 1929, that I last saw her alive on Janvary 25, 1929, and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

..... (duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Psychosis with other brain & nervous diseases (duration) 3 yrs. + mos. + ds.

18 Where was disease contracted if not at place of death? Prior to admission

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) John Irvine McKelway, M. D.

Janvary 26, 1929 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Priest River Ida | Date of Burial: Jan 29 19

20. Undertaker: [signature] | Address: Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED FEB 12 1929

DO NOT WRITE IN THIS SPACE
State File No. 64570

PLACE OF DEATH
County of Custer
City of Challis
Registration District No. 10
Primary Registration District No. 2186
Local Registrar's No. 87
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Antonio Passini

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Miner
(c) Name of employer

9. BIRTHPLACE (city or town) Chiavenna Ter Prate
(State or country) Italy

PARENTS

10. NAME OF FATHER A. Passini
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) unknown

14. Informant Mrs John Gemer
(Address) Challis, Idaho

15. Filed Jan 10, 1929 Edna McKenney
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929 to Jan 4, 1929
that I last saw h[illegible] alive on Jan 4 1929
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. E. Turbyfill, M. D.
2/9, 1929 (Address) Challis

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Challis Idaho	Jan 6 1929

20. Undertaker Jos Ebberts — Address Challis Ida

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64582

PLACE OF DEATH
County of Franklin
City of Riverdale

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No. 4

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jean Neeley

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Female~~ Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept 2 1928

7. AGE — Years | Months: 4 | Days: 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED: Child

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Riverdale Idaho

PARENTS

10. NAME OF FATHER: Milton Neeley

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Riverdale Idaho

12. MAIDEN NAME OF MOTHER: Eva Bessie Green

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Turner Idaho

14. Informant: Milton Neeley
(Address): Riverdale Idaho

15. Filed Feb. 2, 1929 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 6:15 P. m.
The CAUSE OF DEATH* ~~was as follows~~:
Malnutrition
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) A. R. Cutler, M. D.
1-9, 1929 (Address) Preston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverdale Idaho — Date of Burial: Jan 9 29

20. Undertaker: M. W. Hendricks — Address: Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64583

PLACE OF DEATH

County of Franklin
City of Riverdale
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No. 3
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joan Neeley

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fenal
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Sept 2 1928
7. AGE: Years | Months: 4 | Days: 6 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Riverdale Idaho

PARENTS
10. NAME OF FATHER: Milton Neeley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Riverdale Idaho
12. MAIDEN NAME OF MOTHER: Eva Bessie Green
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Turner Idaho

14. Informant: Milton Neeley
(Address) Riverdale Idaho
15. Filed Feb. 2, 1929 A.R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 8 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 6-0 a. m.
The CAUSE OF DEATH* ~~was as follows~~:
Malnutrition
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis?
(Signed) A.R. Cutler, M. D.
1-9, 1929 (Address) Preston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverdale Idaho — Date of Burial: Jan. 9 1929
20. Undertaker: W. W. Hendricks — Address: Preston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1929

PLACE OF DEATH

County of Franklin

City of Preston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 27

Primary Registration District No. 2119

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64584

Local Registrar's No. 10

2. FULL NAME Geo. Washington Worrick

(a) Residence. No. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Male~~ Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 28 1853

7. AGE: 76 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10. NAME OF FATHER: Ephriam Worrick

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Elizabeth Roberts / Virginia

12. MAIDEN NAME OF MOTHER: ~~Unknown~~ Elizabeth Roberts

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14. Informant: Mrs Edward Evans

(Address): Preston Idaho

15. Filed Feb. 8, 1929 — A. R. Cutler, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 28 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 10 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene Worley, M. D.

1-29, 1929 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho — Date of Burial: Jan 30 29

20. Undertaker: M. M. WHendricks P — Address: P

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64585

PLACE OF DEATH

County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2114
Local Registrar's No. 7

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clarence Ricks Wixom

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 12 1909

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20		00	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer and
(b) General nature of industry, business, or establishment in which employed (or employer): School boy
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sharon Idaho

PARENTS

10. NAME OF FATHER: Joseph Wixom

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Lehi Utah

12. MAIDEN NAME OF MOTHER: Alvira Ricks

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Logan Utah

14. Informant: L.E. Wixom
(Address): Preston Idaho

15. Filed Feb. 2, 1929 A.R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to Jan 20, 1929
that I last saw him alive on Jan 20, 1929
and that death occurred, on the date stated above, at 6:20 a.m.
The CAUSE OF DEATH was as follows:
Acute Pulmonary Edema
(duration) yrs. mos. 1 day
CONTRIBUTORY (Secondary) Influenza Pneumonia
(duration) — yrs. — mos. 7 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A.R. Cutler M. D.
Jan, 1929 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho — Date of Burial: Jan. 23 1929

20. Undertaker: M.W. Hendricks — Address: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64586

PLACE OF DEATH

County of Franklin
City of Cederville

Registration District No. 27
Primary Registration District No. 2119
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Sarah J. Rasmussen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James P. Rasmussen

6. DATE OF BIRTH (month, day and year) Aug 19 1886

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
43	4	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minkereek Idaho

PARENTS

10. NAME OF FATHER Thomas Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Sine Jensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant James P. Rasmussen
(Address) Cedervill Idaho

15. Filed Feb. 2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 25th., 1928, to Jan. 17th, 1929
that I last saw her alive on Nove., 1928
and that death occurred, on the date stated above, at 4 pm.
The CAUSE OF DEATH* was as follows:
Squamous cell carcinoma of face. (Antrum)
..... (duration) 1 yrs. 3 mos. ..... ds.
CONTRIBUTORY (Secondary) Infected molar teeth of upper jaw. (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? -----
Did an operation precede death? Yes. Date of Jan. 25th/28
Was there an autopsy? No.
What test confirmed diagnosis? Laboratory.
(Signed) [signature] M. D.
Jan 20th, 1929 (Address) Logan Utah

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Weston Idaho
Date of Burial Jan 21 1928

20. Undertaker MW Mendricks Preston
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64587

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No. 6
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Johanna Whitehead

(a) Residence. No. .... St. ....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 31 1867

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
61	4	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Richmond Utah

PARENTS

10. NAME OF FATHER James Durney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scottland
12. MAIDEN NAME OF MOTHER Sarah Sutton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Della Smith
(Address) Richmond Utah

15. Filed Feb. 2, 1929 T. K. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 10th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1928, to Jan 10 1929, that I last saw her alive on Jan 9 1929, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver Mayo a
Late extended Vagina & all lower
parts (duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) .... (duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of ....
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) H G Stevenson M. D.
Jan 12th, 1929 (Address) Richmond Utah
(Also reg. in Franklin Idaho)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Franklin Idaho	Jan. 13 29

20. Undertaker	Address
M.W. Hendricks	Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64588

PLACE OF DEATH

County of Franklin
City of Franklin

Registration District No. 27
Primary Registration District No. 2117
Local Registrar's No. 5
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Welford Rasc Christensen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 25, 1924

7. AGE: 5 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Preston Idaho

PARENTS

10. NAME OF FATHER: Fredric Christensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Richmond Utah
12. MAIDEN NAME OF MOTHER: Florence Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Richmond Utah

14. Informant: Fred Christensen
(Address): Franklin Idaho.

15. Filed Feb. 2, 1929 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 8 (Month) (Day) 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1928, to Jan 8, 1929
that I last saw him alive on Jan 7, 1929
and that death occurred, on the date stated above, at 4.05 a m.
The CAUSE OF DEATH* was as follows:
Streptococcic Meningitis
(duration) 6 yrs. 6 mos. 9 ds.
CONTRIBUTORY (Secondary) Abscess ear - Otitis Media (duration) 6 yrs. 6 mos. 36 ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Bacterial
(Signed) G. W. Stokes, M. D.
Jan 8, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Richmond Utah	Jan 9 29
20. Undertaker: M. W. Hendricks	Address: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64591

PLACE OF DEATH
County of Franklin
City of Clifton
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No. 11
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ~~Emma~~ Anna Marie Carlson

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 18 1856

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	6	12	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Ole Jensen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Benter Olsen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Albert Carlson
(Address) Preston Idaho

15. Filed Feb. 2, 1929 A. P. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5, 1927, to 1-30, 1929
that I last saw her alive on Jan 29, 1929
and that death occurred, on the date stated above, at 1 a.m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) C. S. Mulford, M. D.
1-31, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clifton Idaho	Feb 3 1929
20. Undertaker	Address
M. W. hendricks	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. RECEIVED FEB 5 1929

County of Fem
City of Emmett

Registration District No.
Primary Registration District No. 4 A
(No. ..... St.)

File No. 64606
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily Burden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married (Write the word.)

6. DATE OF BIRTH. Aug (Month) 6 (Day) 1866 (Year)

7. AGE 62 Yrs. 5 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Texas

10. NAME OF FATHER John Lemons

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joe Burden
(Address) Emmett Idaho

15. Filed 1/18 1929 J L Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-15 1928, to Jan 18 1929, that I last saw her alive on Jan 16 1929, and that death occured on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:
Carbuncle of back of neck and adjacent tissues
(Duration) ..... Yrs. ..... mos. 30 ds.
Contributory (Secondary) Diabetes mellitus
Chronic nephritis
(Duration several yrs. ..... mos. ..... ds.
(Signed) R N Cummins M. D.
1/18 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Emmett Idaho
DATE OF BURIAL 1/19 1929

20. UNDERTAKER C D Buckner
ADDRESS Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-55 M. 1-18-13

RECEIVED FEB 5 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gem

City of Ola

Registration District No.

Primary Registration District No. 6

(No. ..... St.)

File No. 64607

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles T. Webb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widowed (Write the word.)

6. DATE OF BIRTH. Oct. (Month) 10 (Day) 1854 (Year)

7. AGE 74 Yrs. 3 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner and farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER George Webb

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Lydia Mills

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sherman Glenn

(Address) Ola Idaho

15.

Filed 2 1 4 1929 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ prescribed for deceased from 4-17-28 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Probably chronic interstitial nephritis with hypertension

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. N. Cummings M. D.

1-24 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ola, Idaho

DATE OF BURIAL: Jan. 20 1929

20. UNDERTAKER

ADDRESS

SYMS - YORK CO., PTRS. & SDRS. 24854

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHY[illegible] should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statem[illegible] of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. [illegible] FEB

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 64608
Local Registrar's No. 118

1. PLACE OF DEATH
County of Gooding
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24
Primary Registration District No.
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nancy Elizabeth Barnett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	white	Widow

6. DATE OF BIRTH: Jan (Month) 13 (Day) 1848 (Year)

7. AGE: 80 Yrs. 11 Mos. 28 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): W. Virginia

10. NAME OF Father: Jerry McCormick

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jennie Robertson
(Address) Gooding Ida

15. Filed Jan 14 1929 J H Cornwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1929 to Jan 12 1929, that I last saw her alive on Jan 12 1929 and that death occurred on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows: Influenza-Pneumonia

(Duration) ....yrs. ....mos. 30 ds.
Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) J H Cornwell M. D.
1/12 1929 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone Ida — DATE OF BURIAL: 1/16 1929

20. UNDERTAKER: A C Thompson — ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19. RECEIVED FEB 8 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 64609
Local Registrar's No. 119

1. PLACE OF DEATH

County of Gooding
City of ✓
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 24
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Richard Schooler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Jan (Month) 1 (Day) 1869 (Year)

7. AGE: 16 Yrs. Mos. 15 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farming
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF Father: John Schooler

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Henrietta Lawrence

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Wallace
(Address) Twin Falls Ida

15. Filed Jan 16 1929 J H Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-6- 1929, to 1-16- 1929, that I last saw him alive on 1-16- 1929, and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
appendicitis - peritonitis
broncho pneumonia
(Duration) yrs. mos. 10 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J H Cromwell M. D.
1/16 1929 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hagerman Ida
DATE OF BURIAL: 1-17- 1929

20. UNDERTAKER: A E Thompson
ADDRESS: Gooding Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 14 1963

MAY 10 1977

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of .....(name origin; "Cancer' is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 64614

PLACE OF DEATH
County of Idaho
City of Grangeville

CERTIFICATE OF DEATH
Registration District No. 103
Primary Registration District No. 1001
(No. .....)
(If death occurred in a hospital or institution give its name instead instead of street and number.)

Local Registrar's No. 1.

2. FULL NAME Ashley R. Harlan

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isora Harlan

6 DATE OF BIRTH (month, day and year) Nov. 24 1855

7 AGE Years 73 Months 1 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Crawford Ill.

PARENTS
10 NAME OF FATHER Armstead Harlan
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio
12 MAIDEN NAME OF MOTHER Mary Baily
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ct.

14 Informant Isora Harlan
(Address) Grangeville Ida

15 Filed 2-1-, 1929 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 12 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1929, to Jan 12, 1929, that I last saw him alive on Jan 12, 1929, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 5 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? High blood pressure
(Signed) B. Chipman, M. D.
1-12-, 1929 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Grangeville Ida.
Date of Burial 1-14-1929

20. Undertaker C. A. Hancock
Address Grangeville Ida

(Always write with black ink) RECEIVED FEB

TRANSPORTATION OF CORPSE

1. PLACE OF DEATH.
County of Idaho
City of Grangeville

CERTIFICATE OF DEATH.
Registration District No. 103
Primary Registration District No. 1001.
(No. .... St.)

STATE OF IDAHO
BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
File No. 64615
Registered No. 2.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maney Zumwalt

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. Single, Married, Widowed or Divorced. (Write the Word): Widow

6. DATE OF BIRTH. aug 13 (Month) (Day) 1836 (Year)

7. AGE. Yrs. 92 Mos. 5 ds. 13
IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION.
(a) Trade, profession or partcular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE. (State or Country) Ino

10. NAME OF FATHER: Martin

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R O Zumwalt
(Address) Grangeville

15. Filed 2-1- 1929 B. Chipman Local Registrar.

Place Where Remains are to be Sent. Denver Idaho
Date of Shipment ..... 191....

SHIPPING UNDERTAKER
ADDRESS ..... Firm Name .....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 26- 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1929 to June 26 1929; that I last saw her alive on June 26 1929 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH was as follows:
Chronic Interstitial Nephritis

..... (Duration) ..... Years ..... mos. ..... ds.

Contributory (Secondary) Cyst

..... (Duration) ..... Years ..... mos. ..... ds.

(Signed) B. Chipman M. D.
1-29- 1929 (Address) Grangeville Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Sucidial or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days
In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Denver Ida. Date of Burial 1-29 1929

20. UNDERTAKER C. A. Hancock Address Grangeville Ida

The information on this certificate is an exact COPY of the official certificate filed at place of death.

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64624

Local Registrar's No. 8

PLACE OF DEATH
County of Kootenai
City of Coeur D' Alene

Registration District No. 2
Primary Registration District No. 105
(No. Coeur D' Alene Homes)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Francis M. Waggoner

(a) Residence. No. Coeur D' Alene Homes St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) March 7, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
	80	7	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Vir.

PARENTS
10 NAME OF FATHER John Waggoner
11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.
12 MAIDEN NAME OF MOTHER Jemia Collins
13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Chas F. Waggoner
(Address) Post Falls, Ida.

15 Filed Jan 4, 1929 A. D. Drennan Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Jan. (Month) 2 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1928, to Jan. 2, 1929, that I last saw him alive on Dec. 31, 1928, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Hemiplegia.
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John O'Mead, M. D.
Jan 3, 1929 (Address) Coeur D'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Post Falls, Idaho — Date of Burial: Jan 4 1929
20. Undertaker: Mooney Mortuary — Address: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64625

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1051

Local Registrar's No. 9

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Esther M. Crawford

(a) Residence. No. Dessert Hotel St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1917 - 2 - 24

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	10	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise. Ida.

PARENTS

10. NAME OF FATHER Ivan Earl Crawford
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boise - Ida.
12. MAIDEN NAME OF MOTHER Rena Miller.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Delta. Colo.

14. Informant Mrs. R. M. Crawford
(Address) Dessert Hotel

15. Filed 1 - 7 - 1929 D D Freeman Registrar
A. M. L.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows:
Heart trouble
No Doctor

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) D D Freeman, M. D.
Jan 6, 1929 (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. Cemetery	Jan 8 1929
20. Undertaker	Address
Cassedy Funeral Home	C'Alene.

...tion is very important. See instruction on back of certificate. Exact ... so that it may be properly classified.

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64626

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1051
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

2. FULL NAME Hannah Landskow
(a) Residence: No. Coeur d'Alene Homes St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) 1862 - 8 - 8
7. AGE Years 66 Months 5 Days 0 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Christina Norway
PARENTS
10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway
14. Informant Rev. C. F. Johnson,
(Address)
15. Filed 1-12, 1929 D D Drennan Registrar
A. M. G.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 8 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:
Diabetes
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D D Drennan, M. D.
Jan, 1910 (Address)
10

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cem. C D Alene
Date of Burial: 1-10 1929
20. Undertaker: Cassidy Funeral Home
Address: C D Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64627

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 2
Primary Registration District No. 2-27
Local Registrar's No. 11
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Ray

(a) Residence. No. 1007 — 2nd St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Carrie Clarke-Ray

6. DATE OF BIRTH (month, day and year) 1859-10-24

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	2	17	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) New Brunswick
(State or country) Can.

PARENTS

10. NAME OF FATHER ——— Roy
11. BIRTHPLACE OF FATHER (city or town) Canada
(State or Country)
12. MAIDEN NAME OF MOTHER Victoria ———
13. BIRTHPLACE OF MOTHER (city or town) Canada
(State or Country)

14. Informant Mrs Carrie Ray
(Address)

15. Filed 1-12, 1929 D. D. Brennan Registrar
C. M. D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Jan 11, 1929
that I last saw h[illegible] alive on Jan 11, 1929
and that death occurred, on the date stated above, at 9-30 a m.
The CAUSE OF DEATH* was as follows:
Hodgkins disease

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) E. H. Reed, M. D.
1-12, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial.
Forest Cem. C'D'Alene	1-11 1929
20. Undertaker	Address
Casady Funeral Home	C'D'Alene

TION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64628

RECEIVED JAN 4 1929

County of Kootenai
City of Dalton Gardens
Registration District No. 3
Primary Registration District No. 1451
Local Registrar's No. 13

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Aletta Morelius

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Roy Morelius
6. DATE OF BIRTH (month, day and year): 1892 8- 28
7. AGE: Years 36 | Months 4 | Days 17 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Penn.

PARENTS
10. NAME OF FATHER: Elmer Anthony
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Sarah Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn.

14. Informant: Roy Morelius
(Address)

15. Filed Jan 19, 1929 D. H. Grinman Registrar
C. M. C.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11th 1929, to Jan 15, 1929
that I last saw her alive on Jan 15, 1929
and that death occurred, on the date stated above, at 5-45 P m.
The CAUSE OF DEATH* was as follows:
Peritonitis
Puerperal
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E. H. Teed, M. D.
1-18, 1929 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cem. C'Dalene — Date of Burial: 1-18 1929
20. Undertaker: Cassedy Funeral Home — Address: C'Dalene

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations are not permissible. Medical TION is very important. See instruction on back of certificate.

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64629

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1021
Local Registrar's No. 14
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred E. Wommacott

(a) Residence. No. 218 - Wallace St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Martha Wommacott

6. DATE OF BIRTH (month, day and year) 1861 - 11 - 1

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	1	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Real Estate Agent
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Belleville. Ont Canada

PARENTS

10. NAME OF FATHER Geo. B. Wommacott
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ont - Canada
12. MAIDEN NAME OF MOTHER Augustine J. Meyers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Martha J. Wommacott
(Address)

15. Filed Jan 22, 1929 D. H. Brennan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1928, to Dec 23, 1928
that I last saw him alive on Dec 23, 1928
and that death occurred, on the date stated above, at 4:30 p.m.
The CAUSE OF DEATH* was as follows:
Paralysis.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. H. Teed, M. D.
1-21, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest - Cem. C'Dalene	1 - 22 1929

20. Undertaker	Address
Cassedy Funeral Home	C'Dalene

TION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 64630

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 105.1

(No. Reed Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 15

2. FULL NAME Colin K Andersen

(a) Residence. No. 607 Hubbard St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Agnes Andersen

6 DATE OF BIRTH (month, day and year): July 13, 1869

7 AGE: Years 60 | Months 6 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Millworker

(b) General nature of industry, business, or establishment in which employed (or employer): Lumber

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Wm Andersen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Canada

12 MAIDEN NAME OF MOTHER: Catherine McIntosh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Canada.

14 Informant: Mrs N. E. Huff.

(Address) Coeur d'Alene Ida

15 Filed Jan 22 1929 D. D. Doennan Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 20 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June, 1927, to Jan. 20, 1929, that I last saw him alive on Jan 15, 1929, and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows: Chronic myocardial degeneration

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D Wood M. D.

Jan 21, 1929 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Forest Cemetery

Date of Burial: Jan 22 1929

20. Undertaker: Mooney Mortuary

Address: Coeur d'Alene

RECEIVED FEB 1 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64631

Local Registrar's No. 17

2. FULL NAME Barbara Lee Fairchild

(a) Residence. No. 419 - N. 14th St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1929 - 1 - 19

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Ida.

PARENTS

10. NAME OF FATHER Wilber Fairchild

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Overbrook, Kan.

12. MAIDEN NAME OF MOTHER Harriett Knox

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) St. Joseph, Mo.

14. Informant Wilber Fairchild
(Address)

15. Filed 1-23, 1929 D. W. Brennan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-19, 1929, to 1-21, 1929 that I last saw her alive on 1-21-29, 1929 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Prematurely

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Teed, M. D.

1-23, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C'D'Alene	1-23 1929
20. Undertaker	Address
Carsedy Funeral Home	C'D'Alene

TION is very important. See instruction on back of certificate.

RECEIVED FEB 4 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64633

Registration District No. 30

Primary Registration District No. 1051

Local Registrar's No. 20

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME W. C. Downs

(a) Residence. No. Fernan Lake ~~St.~~
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE W.

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Florence Wing-Downs

6. DATE OF BIRTH (month, day and year) 1857-6-5

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
71	7	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Boat

(b) General nature of industry, business, or establishment in which employed (or employer) Liveryman

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ont. Canada

PARENTS

10. NAME OF FATHER John Downs

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Jane Caulder

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs Ethel Hedal

(Address) 1015 Coeur d'Alene Ave.

15. Filed Jan 26, 1929 D. D. Drennan Registrar
A. M. G.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29, 1927, to Jan 17th, 1929

that I last saw him alive on Jan 17, 1929

and that death occurred, on the date stated above, at 9.15 A.M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

..... (duration) 2 yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood test

(Signed) E. H. Teed, M. D.

1-26, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene — Date of Burial 1-27 1929

20. Undertaker Cassedy Funeral Home — Address C D Alene

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 64634

PLACE OF DEATH — CERTIFICATE OF DEATH

County of Kootenai — Registration District No. 20
City of Post Falls — Primary Registration District No. 1057
(No.) — Local Registrar's No. 21

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME William A Payne

(a) Residence. No. Post Falls R.F.D. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec 25-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) London Kentucky

PARENTS

10 NAME OF FATHER John Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) London Kentucky

12 MAIDEN NAME OF MOTHER Louiza Burnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant Mrs Ethel A. Payne
(Address) Post Falls Idaho

15 Filed Jan 28, 1929 D.D. Freeman Registrar
P.M.G.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 27 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:
Death sudden Probably
Pulmonary Heart trouble
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) P.B. Mooney M. D.
Jan 28, 1929 (Address) Post Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Spokane Booth — Date of Burial: Jan 30 1929

20. Undertaker: P B Mooney — Address: Post Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
64634

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, with unfading ink—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—299 d
V. S. No. 98

1 PLACE OF DEATH
County Kootenai State IDAHO Registered No.
Township Post Falls, or Village or
City R.F.D. No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME WILLIAM A. PAYNE

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 25, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	71	1	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) London, ~~Ky.~~ Kentucky.
(State or country)

PARENTS

10 NAME OF FATHER John Payne
11 BIRTHPLACE OF FATHER (city or town) London
(State or country) Kentucky
12 MAIDEN NAME OF MOTHER Louiza Burnett
13 BIRTHPLACE OF MOTHER (city or town) Morris
(State or country) Tennessee

14 Informant
(Address)

15 Filed ----------, 19 ----------
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1929.

17 I HEREBY CERTIFY, That I attended deceased from
----------, 19----, to ----------, 19----,
that I last saw h---- alive on ----------, 19----,
and that death occurred, on the date stated above, at ----------m.
The CAUSE OF DEATH* was as follows:

---------- (duration) ---- yrs. ---- mos. ---- ds.

CONTRIBUTORY (SECONDARY) ----------
---------- (duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death? ----------
Did an operation precede death? ---------- Date of ----------
Was there an autopsy? ----------
What test confirmed diagnosis? ----------
(Signed) ----------, M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64634

PLACE OF DEATH
County of Kootenai
City of Post Falls

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William A. Payne

(a) Residence. No. Post Falls, RFD St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) December 25, 1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9. BIRTHPLACE (city or town) (State or country) London, Kentucky.
10. NAME OF FATHER John Payne
11. BIRTHPLACE OF FATHER (city or town) London (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Eulize Bidrnette
13. BIRTHPLACE OF MOTHER (city or town) Morris (State or Country) Tennessee.

14. Informant Mrs. Wm. A. Payne
(Address) Post Falls, Idaho.

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 27 19 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Death sudden. Probably
valvular heart disease
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) R. B. Mooney, Coroner
Jan. 28, 19 29 (Address) Coeur d' Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64635

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1051
(No.)
Local Registrar's No. 22

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marcette Milger

(a) Residence. ~~No.~~ Cougar Gulch ~~St.~~
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dont Know exact date

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mich.

PARENTS

10. NAME OF FATHER — Berger

11. BIRTHPLACE OF FATHER (city or town) (State or Country) —

12. MAIDEN NAME OF MOTHER Dont-Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant W. J. Mossburgh
(Address)

15. Filed Jan 30, 1929 D D Brennan Registrar
A. M. D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Burned to Death
Invalid - Bedfast
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) No Doctor, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C'Dalene	1 30 1929
20. Undertaker Cassedy Funeral Home	Address C'Dalene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64636

PLACE OF DEATH
County of Kootenai
City of Dalton Gardens

Registration District No. 30
Primary Registration District No. 1051
Local Registrar's No. 23

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles A. Laabs

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alvina Radolof Laabs

6. DATE OF BIRTH (month, day and year) Mar 21, 1854

7. AGE Years 74 Months 11 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Dont Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant A. C. Laabs
(Address) Coeur d'Alene Ida. R2.

15. Filed Jan 30, 1929 D. D. Drennan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1929 to Jan 28, 1929 that I last saw him alive on Did not see him alive and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows Cerebral hemorrhage

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? History
(Signed) John Elwood, M. D.
Jan 30, 1929 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem CD Alene — Date of Burial 1-31 1929

20. Undertaker Cassedy Funeral Home — Address CD Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64637

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1051
Local Registrar's No. 24
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George E Sletmoe

(a) Residence. No. 1025 N Fourth St.
(Usual place of abode)
Length of residence in city or town where death occurred. 24 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Sletmoe

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	6	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mill worker
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS
10. NAME OF FATHER E Sletmoe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER [illegible]
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) [illegible]

14. Informant E B Sletmoe
(Address) Coeur d'Alene Idaho

15. Filed Feb 2, 1929 W D Spearman Registrar
C.M.G.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1924, to Jan. 31, 1929
that I last saw him alive on Jan 30, 1929
and that death occurred, on the date stated above, at 7 A. m.
The CAUSE OF DEATH* was as follows:

Cerebral softening
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteria sclerosis, Cerebral hemorrhage
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) J C Wilson, M. D.
Feb 2, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Forest Cemetery — Date of Burial Feb 1929
20. Undertaker R B Mooney — Address Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 7 1929

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 2141

(No. County Home St.)

File No. 64640

Registered No. 3

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Henry M. Caldwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widowed

6. DATE OF BIRTH: Not known (Month) (Day) 1 (Year)

7. AGE: 77 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Laborer (common)
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Gleaves

(Address) Potlatch, Idaho

15.

Filed Jan 14 1929 W. H. Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 14, 1929 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 7th 1929, to Jan. 14 1929 that I last saw him alive on Jan. 14 1929 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(Duration) yrs. mos. ds.

Contributory (Secondary) Pernicious Hemorrhage

(Duration) yrs. mos. ds.

(Signed) J. W. Stevenson M. D.

1/15 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: ##### Potlatch, Ida.

DATE OF BURIAL: 1/15/29 191

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 4. 10M. 6-20-11. RECEIVED FEB 7 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 2141

(No. County Home St.)

File No. 64641

Registered No. 2

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Andrew F. Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (*Write* the word.)

6. DATE OF BIRTH: July (Month) (Day) 1857 (Year)

7. AGE: 71 yrs. 6 mos. ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Carpenter
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C.J. Freng

(Address) 1805 Main St. Lewiston, Ida.

15.

Filed ..... 191...

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 8, 1929 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1929, to January 1929 that I last saw him alive on Jan. 6th 1929, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 7 yrs. mos. ds.

Contributory (Secondary) Chronic Rheumatism

(Duration) 7 yrs. mos. ds.

(Signed) J. W. Stevenson M. D.

1/9 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was Disease contracted, If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Genesee Valley Cemetery

DATE OF BURIAL: 1/11/29 191...

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11 RECEIVED FEB 7 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 64642
Registered No. 1
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Marie Pavel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (*Write* the word.)

6. DATE OF BIRTH: March 28 1900 (Month) (Day) (Year)

7. AGE: 28 yrs. 9 mos. 8 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work ..... At home
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Petersburg, Vir.

10. NAME OF FATHER: John F. Pavel

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Anna Pribyl

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John F. Pavel
(Address) Moscow, Idaho

15. Filed Jan 7 1929 W H Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 6, 1929 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1928, to Jan 6 1929 that I last saw her alive on Jan 6 1929, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Superative Pyelitis

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Adair M. D.

1/7 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 1-10 1929

20. UNDERTAKER: F. R. Short
ADDRESS: Moscow

SYMS-YORK CO. PRINTERS & BINDERS. BOISE 18672

RECEIVED FEB 7 1929

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)

Registration District No. 101
Primary Registration District No. 1011

File No. 6443
Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac Stewart

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Divorced

6. DATE OF BIRTH
August (Month) 2 (Day) 1871 (Year)

7. AGE
57 yrs. 5 mos. 17 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work ... Common laborer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Thomas Stewart

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Mary S. Rogers

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A.L. Stewart
(Address) Moscow, Idaho

15. Filed Jan 19 1929 W Hearnthers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. (Month) 19, 1929 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1929, to Jan 19 1929 that I last saw h.im alive on " " 191, and that death occurred on the date stated above, at 2:00 A. M.

The CAUSE OF DEATH* was as follows:

Myocarditis.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C Lad. L. Gritman M. D.

1/21 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 1/21/29 191

20. UNDERTAKER: H. R. Short
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

RECEIVED FEB 7 1929

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Moscow

Registration District No. 101

Primary Registration District No. 1011

(No. ....., ... St.)

File No. 64644

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. A. Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (*Write* the word.)

6. DATE OF BIRTH: Oct. 18 (Month) (Day) 1845 (Year)

7. AGE: 83 yrs. 3 mos. 5 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Retired Farmer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Lena Johnson

(Address) 709 Mabell Ave. Moscow, Ida.

15. Filed Jan 24 1929 W. H. Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 23 (Month) 1929 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1928, to Jan 23 1929 that I last saw him alive on Jan 22 1929, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Intestinal Obstruction.
Probably valvulas
No autopsy.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.

1/25 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was Disease contracted, If not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow

DATE OF BURIAL: 1/29 1929

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED JAN 23 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Potlatch

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65

Primary Registration District No. 2145

(No. ..... St.)

File No. 64646

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joel McFeron.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 30 (Day) 1858 (Year)

7. AGE: 70 Yrs. 4 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Robert McFeron

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer Travis

(Address) Potlatch

15. Filed Jan 8th 1929 Dr. J. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2nd 1929 to Jan. 8th 1929, that I last saw him alive on Jan. 7th 1929, and that death occurred on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of Pancreas

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Icterus

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) ~~Jr.~~ F. C. Gibson M. D.

1/8/1929 (Address) Potlatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash. DATE OF BURIAL: Jan 9 1928

20. UNDERTAKER: E. H. Druin ADDRESS: Palouse Wash.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 23 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
File No. 64647
Registered No.

1. PLACE OF DEATH
County of Latah
City of Bottlatch
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Don. Le Roy. Nichols.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: Dec. (Month) 27 (Day) 1928 (Year)

7. AGE: Yrs. Mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bottlatch

10. NAME OF FATHER: James. Nichols.

11. BIRTHPLACE OF FATHER (State or Country): Spokane. Wash.

12. MAIDEN NAME OF MOTHER: Madaline. Hebbard.

13. BIRTHPLACE OF MOTHER (State or Country): Deer. Lodge. Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): James. Nichols.
(Address): Bottlatch

15. Filed Jan 7th 1929 Dr Jm Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 7th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ Jan. 7th 1929, to Jan 7th 1929 that I last saw him alive on Jan. 7th 1929 and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:

Marasmus.

(Duration) Yrs. mos. 11 ds.
Contributory (Secondary): Premature Birth.
(Duration) yrs. mos. ds.

(Signed) Jm. Thompson M. D.
1/7/1929 (Address) Bottlatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bottlatch Cemetery — DATE OF BURIAL: Jan 8th 1929
20. UNDERTAKER: Parents. — ADDRESS: Bottlatch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED FEB 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64652

PLACE OF DEATH
County of Latah
City of Troy
Registration District No. 64
Primary Registration District No. 2144
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number,)

2. FULL NAME Mard Hokanson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 28 - 1845

7. AGE	Years	Months	Days	If LESS than 1 day,
	65	6	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Swanson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Swanson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs Ida Dahlberg
(Address) Deary Ida

15. Filed Jan 31, 1929 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 26, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1929 to Jan 26, 1929
that I last saw her alive on Jan 25, 1929
and that death occurred, on the date stated above, at 8 9 m.
The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Chas. A. Meyer M. D.
Jan 26, 1929 (Address) Troy, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dry creek cem	Jan 29 1929
20. Undertaker	Address
John J. Pickard	Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FEB 2 1929

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64
Primary Registration District No. 2144
(No. ....., ... St.)

File No. 64653
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Wm. Duthie McGregor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: Nov. 3 1855 (Month) (Day) (Year)

7. AGE: 73 yrs. 2 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry business, or establishment in which employed (or employer): Troy Public School

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: Mary Duthie

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Harvey Smith
(Address) Moscow, Idaho

15. Filed Jan 26 1929 Lucy M. Pickerd Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 24, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1929, to Jan 24 1929 that I last saw him alive on Jan 24 1929, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
..... (Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. A. Meyer M. D.
Jan 26 1929 (Address) Troy, Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow, Ida.
DATE OF BURIAL: 1/27 1929

20. UNDERTAKER: H. R. Short
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 2 1929

PLACE OF DEATH

County of Latah

City of Troy

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 64

Primary Registration District No. 2144

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64654

Local Registrar's No. .....

2. FULL NAME Stina Flodin

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years: 70 | Months: 11 | Days: 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Carl Sodstrom
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Kaja Eliasson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Elmer Flodin
(Address) Troy Ida

15. Filed Jan 31, 1929 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 9, 1929 to Jan 12, 1929
that I last saw her alive on Jan. 11, 1929
and that death occurred, on the date stated above, at 10 p.m.
The CAUSE OF DEATH was as follows:
Broncho pneumonia.
(duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Chas. T. Meyer, M. D.
Jan 14, 1929 (Address) Troy, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dry creek cem	Jan 15 1929
20. Undertaker	Address
John J. Pickerd	Troy Ida

RECEIVED FEB 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64655

PLACE OF DEATH

County of Latah
City of ~~Idaho~~ Troy

Registration District No. 64
Primary Registration District No. 2144
(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME John J Thompson

(a) Residence. No. St.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Christina Thompson

6 DATE OF BIRTH (month, day and year): April 27 - 1863

7 AGE: Years 65 | Months 8 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10 NAME OF FATHER: Torstenson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norway Sogne

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant: Mrs Christina Thompson
(Address): Troy Ida

15 Filed Jan 31, 1929 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January (Month) 3 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12 1928 to Jan 3 1929, that I last saw him alive on Jan 3, 1929, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

8

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Chas. A. Meyer M. D.

Jan 3, 1929 (Address) Troy Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow Ida	Jan 6 1929
20. Undertaker	Address
John J. Pickerd	Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64662

PLACE OF DEATH
County of Lewis
City of Craigmont Registration District No. 60
Primary Registration District No. 2129
Local Registrar's No. 2
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Altha Alexander

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of James B. Alexander

6. DATE OF BIRTH (month, day and year) Jan 4 1848

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	—	93	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10. NAME OF FATHER E. R. Sharp
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina
12. MAIDEN NAME OF MOTHER Nancy Warren
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14. Informant W. D. Click
(Address) Craigmont Ida.

15. Filed 2/1, 1929 R. E. Dewell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 17, 29, to Jan 17, 29
that I last saw h alive on Thursday, 19 .....
and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
a Jan 16 Thrombosis Coronary
Arteriosclerosis
Endocarditis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Endocarditis
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) John F. Gee, M. D.
Jan 17, 29 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Craigmont Idaho	Jan 19 1929

20. Undertaker Clyde Cline Address Craigmont Ida Winchester Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19

RECEIVED FEB 7 1929

CERTIFICATE OF DEATH

K

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 64668
Registered No. [illegible]

1. PLACE OF DEATH
County of Minidoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19
Primary Registration District No. 2015
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertha [illegible] Trouger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word.): Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE: 52 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Practical Nurse
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Henry Trouger

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Trouger
(Address) Rupert Idaho

15.
Filed 1 — 10 1929 E H Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 6 (Day) [illegible]9 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1925, to Jan 6 1929
that I last saw h.r alive on Jan 6 1929,
and that death occurred on the date stated above, at 1 Pm. M.
The CAUSE OF DEATH* was as follows:
Carcinoma of breast and metastatic
(Duration) 4 Yrs. 2 mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J B Kennedy M. D.
1-29-1929 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	Jan 9 1929
20. UNDERTAKER	ADDRESS
W. A. Goodman	Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED FEB 7 1929

CERTIFICATE OF DEATH

F

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Paul

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

File No. 64669

Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leslie Broodhead

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: Jan (Month) 9 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jabez H Broodhead

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Etta Curtis

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jabez H Broodhead

(Address) Paul Idaho

15. Filed 1-31 1929 E H Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1929, to Jan 12 1928, that I last saw him alive on Jan 12 19..., and that death occurred on the date stated above, at 5:00 a M.

The CAUSE OF DEATH* was as follows: This child apparently healthy died suddenly date above. Examination after death revealed no definite cause

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Over.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leland Frazier M. D.

1-22 1929 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Heyburn Cem

DATE OF BURIAL: Jan 23 1929

20. UNDERTAKER: W. G. Goodman

ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-35 M. 1-19

RECEIVED FEB 7 19

CERTIFICATE OF DEATH

E

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19

Primary Registration District No. 2015

File No. 6467

Registered No. 12

1. PLACE OF DEATH

County of Minidoka

City of Rupert

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adelbert L. Potter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Apr (Month) 12 (Day) 1867 (Year)

7. AGE: 61 Yrs. 8 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dont Know Utah

10. NAME OF FATHER: Stephen Potter

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Emelia Thorpe

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Potter

(Address) Rupert Idaho

15.

Filed 1-10 1929 E. W. Elmore Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 26 1928, to Jan. 1 1929 that I last saw h... alive on Jan. 1 1929, and that death occurred on the date stated above, at 3:20 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Influenza, chronic valvular disease

(Duration) ..... yrs. ..... mos. 9 ds.

(Signed) E. W. Elmore M. D.

1929 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery I.O.O.F. | DATE OF BURIAL: Jan 6 1929

20. UNDERTAKER: W. G. Goodman | ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

RECEIVED FEB 7 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64678

PLACE OF DEATH
County of Madison
City of Emerson Dist.
Registration District No. 19
Primary Registration District No. 2015
Local Registrar's No. 13
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Helen M. Moncur

(a) Residence. No. Heyburn, Route #1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Harve Moncur

6. DATE OF BIRTH (month, day and year) Nov. 4, 1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	2	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shoneysburg, Wash. Co. Utah

PARENTS

10. NAME OF FATHER James H. Thornton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown Unknown
12. MAIDEN NAME OF MOTHER Helen Thayton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown Unknown

14. Informant Harve Moncur
(Address) Heyburn #1

15. Filed 2-4, 1929 Ett Ebmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1928, to Feb. 3, 1929
that I last saw h[illegible] alive on Jan. 11, 1929
and that death occurred, on the date stated above, at 2 [illegible] 0 m.

The CAUSE OF DEATH* was as follows: Chronic Valvular heart disease

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Ett Ebmore, M. D.
2-4, 1929 (Address) Rupert, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Heyburn Cem.	Feb. 6 1929
20. Undertaker	Address
T. D. Grossman	Burley, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-[illegible]

FEB 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce

City of Melrose

(No. ..... St.)

Registration District No. 92

Primary Registration District No. 2170

File No. 64683

Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Angelina Ross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W	widowed

6. DATE OF BIRTH: May (Month) 5 (Day) 1845 (Year)

7. AGE: 84 Yrs. 8 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housekeeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: John M Williams

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Chrisling Salyer

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRU[redacted]THE BEST OF MY KNOWLEDGE

(Informant) for Roscoe Ross

(Address) Peck Ida

15. Filed 1-28 1929 E. E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1929, to Jan 26 1929, that I last saw h[illegible] alive on Jan 25 1929, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) — Yrs. — mos. 7 ds.

Contributory (Secondary) Hernia

(Duration) 5 yrs. — mos. — ds.

(Signed) E. E. Watts M. D.

19 ..... (Address) Gifford

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Craigmont	1-3 1929
20. UNDERTAKER: Shaw	ADDRESS: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64684

Registration District No. 26
Primary Registration District No. 2069
Local Registrar's No. 1

PLACE OF DEATH
County of Oneida
City of Malad

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Mc Duffey

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) - - - - 1848

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) unknown

PARENTS
10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Joseph Barry.
(Address) Malad Ida.

15. Filed 1/31, 1929 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan - 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1929 to Jan 16, 1929
that I last saw him alive on Jan 16, 1929
and that death occurred, on the date stated above, at 5-a m.
The CAUSE OF DEATH* was as follows:
Myocarditis.
Senility.
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Cystitis.
(duration) 0 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. M. Kerns, M. D.
4/29, 1929 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Malad Ida.	Jan 19
20. Undertaker J. Guy Kerns	Address Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64687

PLACE OF DEATH

County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008.

Local Registrar's No. 3

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Syddia Paulsen.

(a) Residence. No. 1434 - 13th Street. & Ave.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Theodore Paulsen.

6. DATE OF BIRTH (month, day and year) 1878-23 Jan.

7. AGE	Years	Months	Days	If LESS than 1 day,
	50	11	15	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa Del.

PARENTS

10. NAME OF FATHER C. C. Swartz.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Clara Neu.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Theodore Paulsen
(Address) Payette, Ida.

15. Filed Jan 9, 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 7, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1929, to Jan 7, 1929
that I last saw her alive on Jan 6, 1929
and that death occurred, on the date stated above, at 3:15 p. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Right Breast
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical

(Signed) J. C. Woodward, M. D.
Jan 9, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette Ida.	1-9 1929.
20. Undertaker	Address
Glenn C Landon.	Payette, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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RECEIVED FEB 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64688

PLACE OF DEATH
County of Payette
City of Fruitland

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 4

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lula Alice Madsen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of E H Madsen

6. DATE OF BIRTH (month, day and year) Oct 21 1873

7. AGE Years 55 Months 2 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER A Edgecomb
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Amanda Tengler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant E H Madsen
(Address)

15. Filed Jan 20, 1929 J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 19, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 19, 1929, to Jan 19, 1929
that I last saw her alive on Jan 19, 1929
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? no Date of none
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) W J Weese M. D.
Jan 19, 1929 (Address) Ontario, Ore.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Missouri Valley Iowa
Date of ~~Burial~~ Removal Jan 21 1929

20. Undertaker I. H. Adams Address Payette Id.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FEB 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64689

Registration District No. 4
Primary Registration District No. 1008.
Local Registrar's No. 3

PLACE OF DEATH
County of Payette
City of Payette
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chandler J. Lucas.
(a) Residence. No. 403 N. 4th St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 23 1875.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	5	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Construction foreman.
(b) General nature of industry, business, or establishment in which employed (or employer) for government.
(c) Name of employer

9. BIRTHPLACE (city or town) Bellevue (State or country) Michigan

PARENTS
10. NAME OF FATHER Jerome V. Lucas.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Katie Meech
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant C W Lucas.
(Address) Payette, Idaho.

15. Filed Jan 20, 29 J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1928, to Jan. 15, 1929
that I last saw him alive on Jan. 15, 1929
and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:
Myocarditis - (probably rheumatic in origin)
Mitral insufficiency.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? None

(Signed) Merrell R. Lot, M. D.
Jan. 17, 1929 (Address) Payette Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette. Idaho.	1-18 1929.
20. Undertaker	Address
Glenn C Sandon.	Payette. Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1929

PLACE OF DEATH

County of Shoshone

City of Kellogg

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64717

Registration District No.

Primary Registration District No.

Local Registrar's No. 5

(No. 707 McKinley Ave)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Josephine Schmalhausen

(a) Residence. No. 707 McKinley Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Divorced, widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 3, 1848

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
80	9	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wife, retired

(b) General nature of industry, business, or establishment in which employed (or employer): -

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Robinson, Ill.

PARENTS

10. NAME OF FATHER: James Dunlap

11. BIRTHPLACE OF FATHER (city or town) (State or Country): ?

12. MAIDEN NAME OF MOTHER: Nancy Hentz

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

14. Informant: Mary Perle Kennett
(Address) Kellogg, Idaho

15. Filed Jan. 21, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 20, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1918, to Jan 20, 1929

that I last saw her alive on Jan 20, 1929

and that death occurred, on the date stated above, at 6:25 a. m.

The CAUSE OF DEATH* was as follows:

Chronic gastro-enteritis.

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Benign tumor (fibroid?) of colon with frequent hemorrhages there from.

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Geo H Kennett, M. D.

Jan. 21, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane Wash

Date of ~~Burial~~ Cremation: 2/22/29 19

20. Undertaker: M C Thornhill

Address: Kellogg Idaho

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64718

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 6

2. FULL NAME Max Gene LaBare

(a) Residence. No. 47 Price St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 23 – 1928

7 AGE Years: Months: 6 Days: 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Coeur D'Alene Idaho

PARENTS
10 NAME OF FATHER John La Bare
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ashland Wis.
12 MAIDEN NAME OF MOTHER Dorothy Perry
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westboro Wis.

14 Informant John Labare
(Address) Kellogg Idaho

15 Filed Jan. 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 25 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1/4, 1929, to 1/24, 1929, that I last saw him alive on 1/24, 1929, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Erysipelas
(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Acute enteritis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no.
What test confirmed diagnosis?
(Signed) A. S. MacDougall, M. D.
1/25/1929 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Coeur D'Alene Idaho
Date of Burial: Jan 27 1929

20. Undertaker: R. L. Stout
Address: Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

[redacted] SPACE

[redacted] 04719

County of Shoshone

City of Kellogg

Registration District No. 123

Primary Registration District No. 2261

Local Registrar's No. 7

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Bennion

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): 1881

7. AGE: 48 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: B. H. & S. Co.

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (city or town) (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ✓

14. Informant: F. D. Huffman

(Address): Rockford Wash

15. Filed Jan. 30, 1929. Mrs Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/23/1929, to 1/25/1929 that I last saw him alive on 1/25/1929 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary): influenza

..... (duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam

(Signed) A. A. MacDougall, M. D.

1/28/1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rockford Wash. | Date of Burial: 1/29/29 19

20. Undertaker: M Charokis | Address: Kellogg Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64721

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

2. FULL NAME Theodore Brown

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Ella M. Brown

6. DATE OF BIRTH (month, day and year) Apr 1-1854

7. AGE Years 65 Months 9 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) California

PARENTS
10. NAME OF FATHER — Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Noing.
12. MAIDEN NAME OF MOTHER Noing
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Noing.

14. Informant T P Brown
(Address) Kellogg Ida

15. Filed Jan. 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH Mason.

16. DATE OF DEATH Jan (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1928, to Jany 14, 1929
that I last saw him alive on Jany 13, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Cancer of Liver
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) T. R. Mason M. D.
Jany 15, 1929 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Ida
Date of Burial Jan 16 1929

20. Undertaker M. C. Thornhill
Address Kellogg Ida

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64722

PLACE OF DEATH
County of Shoshone
City of Kellogg
Registration District No. 123
Primary Registration District No. 3201
Local Registrar's No. 3
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Susie Martin

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced (or) WIFE of W. Martin
6. DATE OF BIRTH (month, day and year) Sept 25 1880
7. AGE Years 48 Months Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS
10. NAME OF FATHER Thomas Hensley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina
12. MAIDEN NAME OF MOTHER Miss Shelton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14. Informant Washington Martin
(Address) Kellogg, Ida
15. Filed Jan. 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 15, 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1928, to Jany 15, 1929
that I last saw h-d alive on Jany 15, 1929
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:
Emphysema
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Pleura-Pneumonia
..... (duration) ..... yrs. ..... mos. 16 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of Jany 7-29
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. R. Mason M. D.
Jan, 1929 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg, Idaho — Date of Burial: June 17 1929
20. Undertaker: M. C. Thornhill — Address: Kellogg Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64723

PLACE OF DEATH
County of Shoshone
City of Page

Registration District No.
Primary Registration District No.
(No. Page Hotel)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

2. FULL NAME Rollie Justice Jr.
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec 5. 1928
7. AGE Years Months 1 Days 16 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Page Ida

PARENTS
10. NAME OF FATHER Rollie Justice
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Camas Prairie Ida.
12. MAIDEN NAME OF MOTHER Lulu Head
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Burnett, Okla

14. Informant Walter Buchanan
(Address) Page Idaho
15. Filed Jan 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 17 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 11th, 1929, to Jan, 19
that I last saw her alive on Jan 17, 1929,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Influenzal Pneumonia.
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. C. Lindsay, M. D.
1/21, 1929 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Idaho. Date of Burial Jan 18 1929
20. Undertaker M C Sharnheim Address Kellogg

FORM V. S. No. 5-25 M. 1-19. RECEIVED FEB 7 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 64724

Registered No. 9

Registration District No. 77

Primary Registration District No. 2176

1. PLACE OF DEATH

County of Teton

City of Chapin, Ida

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. Marion Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Aug. (Month) 8 (Day) 1849 (Year)

7. AGE: 79 Yrs. 5 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer – when active

(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Ohio Iowa

10. NAME OF FATHER: Chas. Smith

11. BIRTHPLACE OF FATHER (State or Country): N. D.

12. MAIDEN NAME OF MOTHER: Rowena Mc. Fate

13. BIRTHPLACE OF MOTHER (State or Country): N. D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Fred Stone

(Address) Victor, Idaho.

15. Filed 1-31-1929 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 25 1929 to Jan. 30 1929 that I last saw h. alive on Jan. 29 1929 and that death occurred on the date stated above, at 9:00 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) — Yrs. 3 mos. — ds.

Contributory (Secondary) Duodenal hemorrhage

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) L. P. Redner M. D.

1/31/1929 (Address) Driggs, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Victor, Ida., Cemetery

DATE OF BURIAL: Feb. 2 1929

20. UNDERTAKER

ADDRESS

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 64725

PLACE OF DEATH

County of Teton

City of Driggs

CERTIFICATE OF DEATH

Registration District No. 77

Primary Registration District No. 2176

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 1

2. FULL NAME Margret Elizabeth Crandell

(a) Residence. No. Driggs Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. 5 ds. 9 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day and year): Sept 29 1846

7 AGE: Years 82 Months 3 Days 15 If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Council Bluffs. Iowa

PARENTS

10 NAME OF FATHER: Noah T. Guymon

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Margaret Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Springfield Canada

14 Informant: Harvey Leslie Crandall

(Address): Driggs Idaho

15 Filed 1-31-, 1929 Martha Marker Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 15 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1929, to Jan 15, 1929, that I last saw her alive on Jan 15, 1929, and that death occurred, on the date stated above, at [illegible] a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) G. G. Parkinson, M. D.

Jan 16, 1929 (Address) Driggs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Driggs, Idaho

Date of Burial: 1-17- 1929

20. Undertaker: A B Eckersell Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REC'D FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64752

Local Registrar's No.

PLACE OF DEATH

County of Twin Falls
City of Burke Ida.
Registration District No. 39
Primary Registration District No. 2087
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Cibulka Jr
CIBULKA

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 5 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Cibulka

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	9	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Hardware & Furniture
(c) Name of employer Merchant.

9. BIRTHPLACE (city or town) (State or country) Novi Hrady Bohemia

PARENTS

10. NAME OF FATHER Joseph Cibulka Sr
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bohemia
12. MAIDEN NAME OF MOTHER Antonina Klat
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bohemia

14. Informant J. Cibulka
(Address) Burke Ida.

15. Filed 1-10, 1929 J. F. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 9th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-20, 1928, to 1-9-, 1929
that I last saw him alive on 1-9-, 1929
and that death occurred, on the date stated above, at 11-P. m.
The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart

(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Chron. Parn. Nephritis
(duration) 5 or 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) Dr Jennings, M. D.
1-10-, 1929 (Address) Burke Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burke Ida.	Jan 12 1929

20. Undertaker L. D. Johnson Address Burke, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 6-26 M. 7-19.

RECEIVED FEB 2 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
File No. 64754
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls. (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lydia Bennett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov. 2 (Month) (Day) 1847 (Year)

7. AGE: 32 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Frank Robinson

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bennett
(Address) Filer

15. Filed 1-5 19 29 — A. A. Newberry, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4:30 P.M. Jan (Month) 4 (Day) 19 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 19 28, to Jan 4 19 29, that I last saw her alive on Jan 4 19 29, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Shock
R.O. Illness.

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary): R.O. Illness
(Duration) yrs. mos. ds.

(Signed) A. A. Newberry M. D.
1/5 19 29 (Address) Filer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer Cemetery — DATE OF BURIAL: Jan 19 29

20. UNDERTAKER: F. E. Drake — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED FEB 2 1929

FORM V. S. No. 5-20 M. 1-15.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
File No. 64755
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Filer
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond Edward Van Zante

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (write the word.)

6. DATE OF BIRTH: Dec 7 (Month) 28 (Day) 1927 (Year)

7. AGE: 1 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: D Van Zante

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Lola Fay Marshall

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D Van Zante
(Address) Filer

15. Filed 1-6 29 A. A. Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 6 (Day) 1929 (Year) 3:30

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 19 29, to Jan 5 19 29 that I last saw h alive on Jan 5 19 29, and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Rheumatic Fever
(Duration) Yrs. mos. 5 ds.
Contributory (Secondary) Endocarditis
(Duration) yrs. mos. 1 ds.

(Signed) A. A. Newberry M. D.
1-6 19 29 (Address) Filer Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer Cemetery — DATE OF BURIAL: Jan 8 19 29

20. UNDERTAKER: H C Drake — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64756

PLACE OF DEATH

County of Twin Falls

City of Do.

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No. 20

(No. 322 - 3rd ave west)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Quast

(a) Residence. No. 322 - 3rd ave west St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Quast

6. DATE OF BIRTH (month, day and year) Nov 14 - 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	2	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Transfer driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Shipman Bros.

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Fred Quast

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Katie Quast

(Address) 322 - 3rd ave west Twin Falls.

15. Filed 2-10-, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14th, 1928, to Jan 27, 1929

that I last saw h[illegible] alive on Jan 26th, 1929

and that death occurred, on the date stated above, at 4:50 m.

The CAUSE OF DEATH* was as follows: Carcinoma of the stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anaemia

++++ (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of [illegible]

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H E Lamb M. D.

Jan 27th, 1929 (Address) Twin Falls Ida Boyle Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, cemetery	Jan 31 1929
20. Undertaker	Address
Whale Mortuary	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64757

Registration District No.

Primary Registration District No. [illegible]

Local Registrar's No. [illegible]

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dorothy Mae Baldwin

(a) Residence. No. Buhl Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 15 1923

7. AGE Years 5 Months 10 Days 11 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colo.

PARENTS

10. NAME OF FATHER Thos. Baldwin

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Jessie Shryack

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Jessie Baldwin
(Address) Buhl Idaho

15. Filed , 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18, 1929, to Jan 26, 1929 that I last saw her alive on January 26, 1929 and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows: appendicitis, acute gangrenous

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. ? ds.

18. Where was disease contracted if not at place of death? Buhl, Ida

Did an operation precede death? yes Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical course, operative findings, history

(Signed) George C. Halley M. D.

Jan. 28, 1929 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Cemetery

Date of Burial 1/29 1929

20. Undertaker Merville D. Rugg.

Address Buhl Idaho

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64758

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 7085
Local Registrar's No. 15
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wm Hearld Flynn

(a) Residence. No. ..... Twin Falls Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) ~~Oct 13~~ July 2 1924

7. AGE	Years	Months	Days	If LESS than 1 day,
	4	6	20	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER C D Flynn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Ada Elizabeth Withers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant C D Flynn
(Address) Twin Falls

15. Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Jan. 27, 1929, to ....., 19...., that I last saw him alive on Jan 27, 1929 and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:
Burn over entire body, accidental. Threw coal oil in hot stove, and clothing burned entirely off.
(duration) 3 hours. yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) C. S. Weaver M. D.
1/25, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	Jan 26 1929

20. Undertaker F E Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64759

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22

2. FULL NAME Ernie Broner
(a) Residence. No. Kimberly St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 19/1903

7. AGE Years: 25 Months: 7 Days: 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ark.

PARENTS
10. NAME OF FATHER N L Broner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Lizzie Sisco
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn

14. Informant N L Broner
(Address) Kimberly

15. Filed 2-16, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1929, to Jan. 25, 1929
that I last saw him alive on Jan. 24, 1929
and that death occurred, on the date stated above, at 3:1 A m.
The CAUSE OF DEATH* was as follows:
Cerebrospinal Meningitis
(Epidemic form)
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Spinal puncture
(Signed) J M Davis, M. D.
Jan. 26, 1929 (Address) Kimberly Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetary
Date of Burial: Jan 27 1929

20. Undertaker: F E Drake
Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64760

PLACE OF DEATH

County of Twin Falls
City of Twin Falls,

Registration District No. 27
Primary Registration District No. 1085

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rosa A. Miller
(a) Residence. No. 620 Second Ave, West St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 23 1873

7. AGE 55 Years 3 Months 1 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: Lyman Norragon
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pr.a
12. MAIDEN NAME OF MOTHER: Mary Wilkison
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dont Know

14. Informant: Orval Miller
(Address) 620. Second Ave West

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. , 1928, to Jan. 23, 1929
that I last saw her alive on Jan. 1, 1929
and that death occurred, on the date stated above, at 1 pm.
The CAUSE OF DEATH* was as follows: Carcinoma of Left Breast
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Dont Know Probably traumatism
Dont Know (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Dont Know.
Did an operation precede death? no Date of —
Was there an autopsy? no.
What test confirmed diagnosis? None (did not hard it)
(Signed) C A Emer, M. D.
1-24, 1929 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls, Date of Burial: Jan 26 1929

20. Undertaker: P. J. Grossman Address: Twin Falls

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64761

PLACE OF DEATH
County of Twin Falls
City of Do

Registration District No. 37
Primary Registration District No. 1285
(No. Twin Falls Co. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. Sept 13

2. FULL NAME Clarance Albert Norris

(a) Residence. No. 3 miles East of Twin Falls St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 15 - 1910

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
17	7	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Quincy Norris

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Clara Harford

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas.

14. Informant
(Address)

15. Filed 2-10, 1929 H. M. Scott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29, 1928, to Jan 21, 1929
that I last saw him alive on Jan 21, 1929
and that death occurred, on the date stated above, at 9:00 P. m.
The CAUSE OF DEATH* was as follows:

Cerebro-spinal fever

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Culture, Spinal fluid

(Signed) Chas. K. Scott M. D.
Jan 22, 1929 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls cemetery	Jan 23 1929
20. Undertaker	Address
White Mortuary	Twin Falls, Idaho

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64762

PLACE OF DEATH
County of Twin Falls,
City of Do.

Registration District No. 37
Primary Registration District No. 1085
(No. Twin Falls Co. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. alexander

2. FULL NAME Lee Harral
(a) Residence. No. 3½ miles S.W. of Twin Falls. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Harral

6. DATE OF BIRTH (month, day and year) April 6th 1890

7. AGE Years 38 Months 9 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER John W. Harral
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Medora Cunnington
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tennessee

14. Informant Ivan Harral
(Address) Twin Falls, Idaho.

15. Filed [illegible], 19[illegible] [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30, 1929, to Jany 21, 1929
that I last saw him alive on Jany 21st, 1929
and that death occurred, on the date stated above, at 9:15 P m.
The CAUSE OF DEATH* was as follows:
Ileus, Post Operative.
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Appendicitis Chronic, Adhesionitis.
(duration) yrs. 18 mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? yes Date of Jany 18th/28
Was there an autopsy? yes
What test confirmed diagnosis? Laboratory & autopsy
(Signed) Duncan L. Alexander, M. D.
1924, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls cemetery
Date of Burial Jan 24 1929

20. Undertaker White Mortuary
Address Twin Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64763

PLACE OF DEATH FEB 12 1929

County of Jerome
City of Hazelton

Registration District No. 37
Primary Registration District No. 2185
(No. Residence 3 miles So. of Hazelton
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15

Clouchek

2. FULL NAME George Grant Judson
(a) Residence. No. So of Hazelton, Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ada Judson

6. DATE OF BIRTH (month, day and year) March 8-1871

7. AGE Years 57 Months 10 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Lewis Judson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Weltha Roger
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs. Ada Judson
(Address) Hazelton, Idaho.

15. Filed 2-10-, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18, 1929 to Jan 21, 1929
that I last saw him alive on Jan 21, 1929
and that death occurred, on the date stated above, at 9:45 P.m.
The CAUSE OF DEATH* was as follows:
Apoplexy.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H. W. Clouchek, M. D.
Jan 21, 1929, (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls cemetery
Date of Burial: Jan 27 1929

20. Undertaker: White Mortuary
Address: Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED FEB 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 64764
Registered No. 21

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls County (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information. Grid Hospital

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James M. Bartley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June 22 1887 (Month) (Day) (Year)

7. AGE: 41 Yrs. 6 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Kesakiah Bartley

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Martha Oakley

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs James M Bartley
(Address) Burke Idaho

15. Filed 2-10- 1929 H. M. Lee
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 18th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23rd 1928 to January 18th 1929
that I last saw h.. alive on January 18 1929
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Splenic Infection Streptococcus
(Duration) Yrs. 1 mos. ..... ds.
Contributory (Secondary) Dilatation Heart, Myocarditis
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Duncan L Peterman M. D.
1/18 1929 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 days. In the State 9 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Burke Idaho
Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Burke Idaho
DATE OF BURIAL: Jan 20 1929

20. UNDERTAKER: L Johnson
ADDRESS: Burke Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64765

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
Registration District No. [illegible]
Primary Registration District No. 165
Local Registrar's No. 16
(No. County General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Patricia Louise Hanlon

(a) Residence. No. 135 Walnut St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan ~~18~~ 14 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Twin Falls Idaho.

PARENTS

10. NAME OF FATHER Walter Hanlon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colo.
12. MAIDEN NAME OF MOTHER Orra Collins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Neb.

14. Informant Walter Hanlon
(Address) 135 Walnut St. Twin Falls,

15. Filed [illegible], 19[illegible] [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 18 (Day) 19 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18th 1929 to Jan 18th 1929
that I last saw h[illegible] alive on Jan 18th 1929
and that death occurred, on the date stated above, at 5 PM.

The CAUSE OF DEATH* was as follows:
Intra-cranial Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Blood Leaked Clotting Power
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Observation
(Signed) John J. Grossman, M. D.
1-22 1929 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Idaho	Jan. 21 1929
20. Undertaker P.J. Grossman	Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64766

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No. 5
Primary Registration District No. 1035
Local Registrar's No. 11
(No. Co. Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph C. Stooker
(a) Residence, No. 403 5th Ave East City St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): June 14 1851
7. AGE: Years 77 | Months 7 | Days 4 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Engineer (Surveyor)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): N.C.

PARENTS
10. NAME OF FATHER: John Stooker
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Mrs. R. R. Thompson
(Address): Twin Falls 403 5th Ave E
15. Filed 2-11, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 18 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1928 to Jan 18 1929
that I last saw him alive on Jan 18 1929
and that death occurred, on the date stated above, at 5 30 p.m.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis General.
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Gangrene leg Right town 1/2
(duration) yrs. 2 mos. 15 ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Laboratory
(Signed) Duncan L. Alexander M. D.
1-29-29 19 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Idaho — Date of Burial 19
20. Undertaker: H. F. Grossman — Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64767

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 21

Primary Registration District No. 1382

Local Registrar's No. 10

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry J. Dinkelacker

(a) Residence. No. 238, 7th Ave North St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Oct 22 1852

7. AGE: Years 77 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Electrician

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10. NAME OF FATHER: Henry Dinkelacker

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Spidel

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Harry L. Dinkelacker

(Address): Twin Falls

15. Filed ..... , 19..

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1929 (Year) Scott 8.30

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1928, to Jan 16, 1929

that I last saw him alive on Jan 16, 1929

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): unresolved lobar pneumonia

..... (duration) ..... yrs. 2 mos. 15 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) Chas R Scott, M. D.

Jan 18, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: T Falls Cemetary | Date of Burial: Jan 18 1929

20. Undertaker: T E Drake | Address: T Falls

FORM V. S. No. 5-15 M. 1-19. RECEIVED FEB 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Twin Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39

Primary Registration District No. 2085

(No. ....., ... St.)

File No. 64769

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Curtis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Mar. (Month) 11 (Day) 911 (Year)

7. AGE: 16 Yrs. 10 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) Wife

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: E J Goodrich

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Stella Braden

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E J Goodrich

(Address) Twin Falls

15.

Filed 2 10 1929 [illegible]

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-8-1929 to 1-13-1929 that I last saw her alive on 1-12-1929 and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows: Streptococci Septicemia

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Streptococci sorthroat

..... (Duration) ..... yrs. ..... mos. 8 ds.

(Signed) H N Leete M. D.

1-13 1929 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 9 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? at home

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: T Falls Cemetery

DATE OF BURIAL: Jan 16 1929

20. UNDERTAKER: F E Drake

ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED FEB 12 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District No. 2085
File No. 64770
Registered No. [illegible]

1. PLACE OF DEATH
County of Twin Falls
City of Hollister
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lizzie M. Bassford
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept (Month) 23 (Day) 1875 (Year)

7. AGE: 52 Yrs. 3 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: J C Marler

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Mabel Coles

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C M Bassford
(Address) Twin Falls Rt 1

15. Filed 2-10-1929 H. N. Leete Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1-15
Jan (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 - 1929 to Jan 9 1929 that I last saw h-r alive on Jan 8 - 1929 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemmorage

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) High Blood pressure
(Duration) 1 yrs. 5 mos. 9 ds.

(Signed) H N Leete M. D.
1-12 1929 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Berger Ida
Former or usual residence Berger Ida

19. PLACE OF BURIAL OR REMOVAL: Filer Cemetary | DATE OF BURIAL: Jan 13 1929

20. UNDERTAKER: F E Dusk | ADDRESS: T Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19 FEB 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Twin Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. Cloud Gap [illegible] St.)

File No. 64771

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry F. Kronkel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Whole

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 1 (Month) (Day) 1911 (Year)

7. AGE: 16 Yrs. 1 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: D M Kronkel

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Sarah Wilkerson

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C H Hooting

(Address) Twin Falls

15. Filed 2-10- 1929 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1-30 Jan (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1929, to Jan 6th 1929, that I last saw him alive on Jan 6th 1929, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Spinal Meningitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H E Lamb M. D.

19..... (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Cemetery Jan 9 1929

DATE OF BURIAL

20. UNDERTAKER: H E Drake

ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. FEB 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Do.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 085

(No. 346 - Jimmy St.)

File No. 64772

Registered No. —

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Belle Harriet Cheney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec (Month) 5 (Day) 1928 (Year)

7. AGE: 0 Yrs. 1 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Twin Falls, Idaho.

10. NAME OF FATHER: Claude Cheney

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER: Emma Huether

13. BIRTHPLACE OF MOTHER (State or Country) So. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Claude Cheney (by PB)

(Address) 346 - Jimmy St. Twin Falls

15. Filed 2-10- 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, ~~That I attended deceased from~~ ..... 19..., to ..... 19...,

that I last saw her ~~alive on~~ 1/6 1929,

and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Probably pneumonia

Death very sudden.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Wexwell M. D.

1/7 1929 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Twin Falls cemetery

DATE OF BURIAL: Jan 7 1929

20. UNDERTAKER: White Mortuary

ADDRESS: Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. [illegible] M. 1-18

RECEIVED FEB 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6478

Registered No. [illegible]

1. PLACE OF DEATH

County of Twin Falls.

City of Twin Falls.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. [illegible]

Primary Registration District No. [illegible]

(No. [illegible] St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Michael Vincent

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widower

6. DATE OF BIRTH — — 1835
(Month) (Day) (Year)

7. AGE 92 Yrs. — Mos. — ds. —

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER M Vincent

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. D. Vincent

(Address) Filer

15. Filed [illegible] 1929 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1928, to Jan 6 1929, that I last saw h..... alive on Jan [illegible] 1929, and that death occurred on the date stated above, at [illegible] P.M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) [illegible] Yrs. [illegible] mos. 9 ds.

Contributory (Secondary) Senile [illegible]

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Newberry M. D.

Jan 8 1929 (Address) Filer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Des Moines Iowa	..... 19.....

20. UNDERTAKER F. C. Drake ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64774

Local Registrar's No. 24

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No.

Primary Registration District No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Novacek

(a) Residence. No. 1 Burke Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	W	Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb-14-1855

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Czecho Slovakia

PARENTS

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant Charles Novacek

(Address) Burke Idaho

15. Filed 2-10, 19 29 Wm. Leet Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5-January 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-January, 1929, to 4-January, 1929 that I last saw him alive on 4-January, 1929 and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

a) Cerebral bleeding probably due to arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? digital examinations

(Signed) H. W. MacNamara M. D.

5-January, 1929 (Address) Burke, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burke Cemetery	Jan 7 1929
20. Undertaker	Address
Powell & Fuggs	Burke Ida

FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64775

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 3
Primary Registration District No. 1855
Local Registrar's No. 8
(No. County Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margie Jane Webb
(a) Residence. No. Hazelton Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 12-1900

7. AGE 28 Years | Months | 21 Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER T. A. Weatherby

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wash.

12. MAIDEN NAME OF MOTHER Dora E. King

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unk.

14. Informant Wm. Webb
(Address) Hazelton Ida.

15. Filed [illegible], 19[illegible] [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH 166

16. DATE OF DEATH Jan (Month) 1st. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1928, to Jan. 1, 1929
that I last saw her alive on Jan 1, 1929
and that death occurred, on the date stated above, at 12 noon m.
The CAUSE OF DEATH* was as follows:

Bichloride Mercury poisoning
accidental
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? no

(Signed) J. R. Morgan, M. D.
1/1 1929 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Filer Ida	Jan 4 1929
20. Undertaker P. F. Grossman	Address Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6[illegible]7

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 9

PLACE OF DEATH

County of Canyon
City of Caldwell
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Poke Smith

(a) Residence. No. 811 So 13th St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. Dec 17-1850

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	1	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER Jasper Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER. Deanthy Hoyt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant J B Smith
(Address) 811 So 13th Caldwell Ida

15. Filed 2-5-, 1929 John L. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec, 1928, to Feb 3, 1929
that I last saw h[illegible] alive on Feb 3, 1929
and that death occurred, on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(duration) 2 yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? X Ray
(Signed) C. W. Montgomery, M. D.
2/4, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Feb 5 1929
20. Undertaker	Address
C. V. Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64778

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 8

PLACE OF DEATH
County of Canyon
City of Wilder
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Owen Stilwell
(a) Residence. No. ..... Wilder, Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 22 - 1869

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	2	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER John Stilwell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Elmer F. Stilwell
(Address) Wilder Ida

15. Filed 2-5-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH 14a

16. DATE OF DEATH
Feb (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1929, to Feb 3, 1929
that I last saw him alive on 6 10 P M, 1929
and that death occurred, on the date stated above, at 6 30 P m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemmorrhage

(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Brights
(duration) / yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis? Lab.
(Signed) Robert E Talbot M. D.
Feb 4, 1929 (Address) Wilder Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Feb 6th 1929
20. Undertaker	**Address**
C. V. Peckham	Caldwell Ida

Copy

February 28, 1930.

Dr. Robert E. Talbot,
Hamsdale, Idaho.

Re: 64778

Dear Doctor:

In order to complete the death certificate of WILLIAM OREN STILWELL who died at Wilder on February 3rd, 1930, would you kindly advise was he SINGLE, MARRIED, WIDOWED OR DIVORCED?

We enclose herewith addressed stamped envelope for your convenience in returning this letter with the desired information.

Respectfully yours,

C. K. Macey,
State Registrar.

Dear Doctor: March 20-1929.

We have not received a reply. Could we please have this information?

He was Married

R.E.J.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

...ry item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS ...e CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... ...ry important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS ...
State File No. 6477...

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 5

(No. 235 South 10th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Alice Boyenger.

(a) Residence. No. Boise, Idaho R.#4. St.
(Usual place of abode) (If nonresident give city or town and ...)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): ~~Married~~ Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Garret Boyenger.

6. DATE OF BIRTH (month, day and year) April 15th 1860

7. AGE: 68 Years; Months: 9; Days: 16; If LESS than 1 day, ---------- hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Holland.

PARENTS

10. NAME OF FATHER: Albert Bronkhaust.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Holland.

12. MAIDEN NAME OF MOTHER: Alice --------

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Holland.

14. Dr. C. L. Boyenger.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 1st 1929 (Month) (Day)

17. I HEREBY CERTIFY, That I attended deceased from Sep 17 1928, to Feb 1 ... that I last saw her alive on Jan. 31st, 1929 and that death occurred, on the date stated above, at 3:30 P.M. m.

The CAUSE OF DEATH* was as follows: Uraemic poisoning acute nephritis — with dropsy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): High blood pressure and valvular heart lesions.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Boick, M. D.

2/2/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial

19

RECEIVED

64780

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64780

PLACE OF DEATH
County of Shoshone
City of Avery

Registration District No. 127
Primary Registration District No. 2400
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5

2. FULL NAME Frank Moore

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) ✓

7. AGE ✓ Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Trail Foreman U.S. Forest Service
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) ✓
(State or country)

PARENTS

10. NAME OF FATHER ✓

11. ✓ BIRTHPLACE OF FATHER (city or town) .....
(State or Country)

12. ✓ MAIDEN NAME OF MOTHER

13. ✓ BIRTHPLACE OF MOTHER (city or town) .....
(State or Country)

14. ✓ Informant .....
(Address)

15. ✓ Filed Feb 18, 1929 E. H. Heath
Registrar

MEDICAL CERTIFICATE OF DEATH

179

16. DATE OF DEATH Jan (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1929, to —, 19....
that I last saw him ~~alive~~ dead on Jan 7, 1929
and that death occurred, on the date stated above, at 9 m.
The CAUSE OF DEATH* was as follows:
accidently burned to death in his home

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) O. Meraga Dep Coroner, M. D.
Jan 8, 1929 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Placed in Receiving Vault
Date of Burial: Jan 9 1929

20. Undertaker: Mitchell & Meraga
Address: St Maries Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

64781

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64781

Registration District No. 90
Primary Registration District No. 2168
Local Registrar's No. 17

PLACE OF DEATH
County of Shoshone
City of Wallace
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna M. Stanton

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Claude Stanton

6. DATE OF BIRTH (month, day and year) July 25 1880

7. AGE	Years	Months	Days	If LESS than 1 day,
	48	6	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Hayes, Kansas

PARENTS
10. NAME OF FATHER —
11. BIRTHPLACE OF FATHER (city or town) (State or Country) —
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant W. A. Shaw Wallace
(Address)

15. Filed Jan 16, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-2, 1928, to 2-4, 1929
that I last saw h[illegible] alive on 2-4, 1929
and that death occurred, on the date stated above, at 11:45 a.m.
The CAUSE OF DEATH* was as follows:
Nephritis (acute)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension 2 years
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Burke
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Symptoms (Uremia)
(Signed) W. F. Robertson M. D.
2-4, 1929 (Address) Osburn Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	19
20. Undertaker W. A. Shaw	Address Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FEB 13 1929

44783

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64783

PLACE OF DEATH
County of Madison
City of Burton.

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 8
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Niels Henry Tickstad

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 22 1852

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	2		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hop Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Holmstrand (State or country) Norway

PARENTS

10. NAME OF FATHER Hans Christian Tickstad
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Helen K. — — —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Mrs Helen Mabrahall
(Address) Rexburg.

15. Filed 2/11, 1929 J Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1929, to Jan. , 1929
that I last saw him alive on Jan. 13, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
1. Chronic Myocarditis.
2. Arteriosclerosis.
3. Chronic Nephritis.
4. Senility (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H H Rigby, M. D.
Jan. 23, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg	1/26 1929

20. Undertaker	Address
A E Eckersell	Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MAR 5 1929

64784

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64784

PLACE OF DEATH
County of Twin Falls
City of Do.

Registration District No. 37
Primary Registration District No. [illegible]
(No. Twin Falls Co Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 25

2. FULL NAME Ernest E. Tate
(a) Residence. No. Kimberly, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jessie Tate

6. DATE OF BIRTH (month, day and year): April 2-1891

7. AGE: Years 37 Months 10 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Truck driver
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Tenn.

PARENTS
10. NAME OF FATHER: Elijah Tate
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn.
12. MAIDEN NAME OF MOTHER: Mary Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn.

14. Informant: Mrs. John Bigley
(Address) Twin Falls, Idaho.

15. Filed ~~3-10~~ 3-4-1929, 19 29 H. N. Leets Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3, 1929, to Feb 7, 1929
that I last saw him alive on Feb 7, 1929
and that death occurred, on the date stated above, at 9:30 P. m.
The CAUSE OF DEATH* was as follows: Cerebro Spinal Meningitis (Epidemic Form)
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Kimberly Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Final etc
(Signed) Jer Davis, M. D.
Feb 12 1929 (Address) Kimberly Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery
Date of Burial: 7/13 1929.

20. Undertaker: White Mortuary
Address: Twin Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

64785

Form V. S. No. 5. 10M. 6-28 RECEIVED MAR 7 1929 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 64785

Registered No. 11

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Joseph Edward Mudgett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: "hite

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Dec. 4, (Month) (Day) 1848 (Year)

7. AGE: 80 yrs. 2 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Mudgett
(Address) Moscow Ida.

15. Filed Mch 1 1929 W. H. Matthews Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 25th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1928, to Feby 25 1929 that I last saw h[illegible] alive on Feby 25 1929, and that death occurred on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma Rectum c Complete obstruction for last 7 days.
(Duration) 4 yrs. 5 mos. ds.
Contributory (Secondary) Ileostomy - Colostomy done on 24th -
(Duration) yrs. mos. ds.
(Signed) C. H. Nagel M. D.
2/28 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 2/28 1929

20. UNDERTAKER: F. R. Short
ADDRESS: Moscow

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

64786

RECEIVED MAR 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64786

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Guerino Nussio

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: March 7 1882.

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 46 Months 11 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Lumber Mill.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Italy

PARENTS
10. NAME OF FATHER: J Nussio
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Italy
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Daisy Nussio
(Address): Potlatch Ida

15. Filed Feb. 12th, 1929. Dr Jw. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1929, to Feb. 10th, 1929
that I last saw him alive on Feb. 9th, 1929
and that death occurred, on the date stated above, at 8.40 a.m.
The CAUSE OF DEATH* was as follows:
Acute influenzal pneumonia

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Dr Jw. Thompson M. D.
Feb. 12th, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Potlatch Ida — Date of Burial: Feb. 1929

20. Undertaker: E. M. Irwin. Palouse — Address: Wash.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Dr. Tourney

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64787

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 42

(No. 412 Grove Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Roy Cooper.

(a) Residence. No. 412 Grove St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ----------

6. DATE OF BIRTH (month, day and year): August 1865

7. AGE: Years 63 | Months | Days | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Painter.

(b) General nature of industry, business, or establishment in which employed (or employer): .

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Baker City, Oregon.

PARENTS

10. NAME OF FATHER: William H. Cooper.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Cooper Co. Mo.

12. MAIDEN NAME OF MOTHER: Martha C. Chandler.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: W. C. Cooper.
(Address): Boise, Idaho.

15. Filed 2-11-, 1929 Paula McDonald, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 10th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May -10-, 1927, to Feb -9, 1929

that I last saw h~~am~~ alive on Feb 9, 1929

and that death occurred, on the date stated above, at 3:30P.M m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

Morethan (duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Under Nourishment

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Dr. Tourney, M. D.

2/11/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 2/13/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64788

PLACE OF DEATH

County of Ada

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 43

(No. St Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Roger. Stephen. Meltvedt

(a) Residence. No. Parma Idaho. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov-8-1926.

7. AGE Years 2 Months 2 Days 23. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Parma Idaho.

PARENTS

10. NAME OF FATHER Christopher Meltvedt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Alene Stevens

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Christopher Meltvedt

(Address) Parma Idaho R 2.

15. Filed 2-1-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1-31- 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-13-, 1929, to 1-31-, 1929

that I last saw him alive on 1-30-29, 19..

and that death occurred, on the date stated above, at 3 A.m.

The CAUSE OF DEATH* was as follows: Cerebro-Spinal Meningitis

(duration) ..... yrs. ..... mos. 25 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Parma, Idaho.

Did an operation precede death? yes Date of 1-30-29

Was there an autopsy? yes

What test confirmed diagnosis? Spinal Puncture

(Signed) Ernest E. Lawbaugh M. D.

1-31-, 1929 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery

Date of Burial Feb. 1 1929

20. Undertaker Summers & Krebs

Address Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 6

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1929 CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. 716 E. Jefferson St.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64789

Local Registrar's No. 44

2. FULL NAME William Henry Jellison

(a) Residence. No. 716 E. Jefferson St. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 2 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	9	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jellison Bros. Marble Co.

9. BIRTHPLACE (city or town) (State or country) Mattoon, Coles Co. Illinois

PARENTS

10. NAME OF FATHER Edwin A. Jellison

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Winchester, Scott Co. Illinois

12. MAIDEN NAME OF MOTHER Nancy Jellison

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montezuma, Parke Co. Indiana

14. Informant Minnie Jellison.

(Address) 716 E. Jefferson St. Boise, Idaho.

15. Filed 2-14-, 1929 Paula M. Doncaed Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 11½ (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9th, 1929, to Feb 11½, 1929

that I last saw h. alive on Feb 11½, 1929

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows: Hemorrhage (cerebral) and acute nephritis. Traumatic Convulsions.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Albuminuria

(duration) yrs 4½ mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Buck M. D.

Feb 13, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	2/14 1928
20. Undertaker Schreiber & McCann	Address Boise, Ida

Bulletin

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED MAR 6 1929

DO NOT WRITE IN THIS SPACE
State File No. 64790

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 45

(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William A. Johnson

(a) Residence. No. Pacific Hotel St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 21 1864

7. AGE: 65 Years | Months: 1 | Days: 8 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Worth Montgomery

9. BIRTHPLACE (city or town) (State or country): Kansas City Missouri

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Margherite Johnson
(Address) Hagerman Idaho

15. Filed 2-14, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 13 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1928, to Feb 12, 1928

that I last saw him alive on Feb 11, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cancer of prostate

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Cottrell M. D.

....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill | Date of Burial: 2-15- 1929

20. Undertaker: Summers & Krebs | Address: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64791

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 46

(No. St. Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Frusetta

(a) Residence. No. Owyhee Hotel St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Not obtainable

6. DATE OF BIRTH (month, day and year)

7. AGE Years About 55 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chef

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Owyhee Hotel Co

9. BIRTHPLACE (city or town) (State or country) Not obtainable

PARENTS

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant A. Schneider,
(Address)

15. Filed 2/23/, 1929 Paula McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb - 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/22, 1929, to 2-22, 1929

that I last saw him alive on 2-22, 1929

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Reflexes etc

(Signed) S W Family, M. D.

2/23, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Portland, Ore

Date of Burial Shipment Feb. 24 1929

20. Undertaker Schneider & McCann

Address Boise, Ida

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64792

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1007
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 47

2. FULL NAME Mable Blanche Butler

(a) Residence. No. New Plymouth Ida St. New Plymouth Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Wht.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 3 1905

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	9	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Printer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Mr Goldsmith

9. BIRTHPLACE (city or town) (State or country) New Plymouth Ida

PARENTS

10. NAME OF FATHER John O Butler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Maggie Littlejohn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Jim Butler
(Address) New Plymouth

15. Filed 2-23, 1929 Adele M Doucet Registrar
Almond

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1928, to Feb, 1929
that I last saw h[illegible] alive on 2-21, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Tuberculosis Pulmonary
(duration) 2 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Generalized TBC
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Payette
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Positive Sputum
(Signed) F W Almond, M. D.
2-22, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
New Plymouth Ida	Feb 23 1929
20. Undertaker	Address
Schneider & McCann	Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64793

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 48
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George W. Lewis

(a) Residence. (Usual place of abode) No. 1003 N 6, St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Florence M. Lewis,

6. DATE OF BIRTH (month, day and year) Sept 28-1874

7. AGE	Years	Months	Days	If LESS than 1 day,
	54	4	15	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work State Budget
(b) General nature of industry, business, or establishment in which employed (or employer) Commissioner
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Merriah R Lewis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Amanda J Allred
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Mrs George W Lewis
(Address) 1003 N 6 Street Boise Idaho

15. Filed 2-15-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2- (Month) 13- (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-22-, 1928, to 2-13-, 1929
that I last saw h— alive on 2-13-, 1929
and that death occurred, on the date stated above, at 2 30 P. m.
The CAUSE OF DEATH* was as follows: Tuberculosis Pulmonary

(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Hemorrhage
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Ernest E. Hughes, M. D.
2-15-, 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Feb 17 1929
20. Undertaker: Summers & Kirke — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64794

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 49
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mike Garey
(a) Residence. No. (Usual place of abode) St. Barber Idaho
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): February 28-1888
7. AGE: Years 41 | Months 11 | Days 28 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS
10. NAME OF FATHER: Michael Garey.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Michigan
12. MAIDEN NAME OF MOTHER: Clara Jobitt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada,

14. Informant: T. F. Hoffman,
(Address): Barber Idaho
15. Filed 2-28-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 26 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1929, to Feb 26, 1929
that I last saw him alive on Feb 26, 1929
and that death occurred, on the date stated above, at 11:45 m.
The CAUSE OF DEATH* was as follows:
Epilepsy - Chronic for 20 years.
Acute
(duration) yrs. mos. 5. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Barber Ida.
Did an operation precede death? No Date of
Was there an autopsy? Yes.
What test confirmed diagnosis?
(Signed) W. A. Forlach, M. D.
2/26, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Feb 28 1929
20. Undertaker: Summers & Hicks — Address: Boise Idaho.

Iowa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64795

PLACE OF DEATH
RECEIVED MAR 6 1929
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 5
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Wake

(a) Residence. No. ..... St. ..... Burley Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 6-1852

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76.	9	2.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Charles Wake
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Robert C. Wake
(Address) Malta Idaho

15. Filed 3/8, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1929, to Feb. 8, 1929
that I last saw him alive on Feb. 7, 1929
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Peritonitis cause undetermined (duration) at least yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Chas R. Lowe, M. D.
Feb. 8, 1929 (Address) 215 1st Nat. Bank Bldg. Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Idaho	Feb 12 1929
20. Undertaker	Address
Summers & Kreb	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64796

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 51
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Hall
(a) Residence. No. ..... St. Emmett, Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): ?
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): About 1849
7. AGE: About 80 Years; Months —; Days —; If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: ?
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): ?

PARENTS
10. NAME OF FATHER: Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: A. Schreiber
(Address) Boise, Ida
15. Filed 2/7/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 29th (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis
Several years duration (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. L. Reynolds, M. D.
2/9 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. John's Cemetery — Date of Burial: 1/31 1929
20. Undertaker: Schreiber & McCann — Address: Boise, Ida

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64797

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 52

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edwin A. Jellison

(a) Residence. No. 716 E. Jefferson St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 85, Months 9, Days 11. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired ~~Lyro making Ironing boards~~
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Winchester, Scott Co. Illinois

PARENTS
10. NAME OF FATHER: Meltiak Jellison
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Hancock Co Maine
12. MAIDEN NAME OF MOTHER: Nancy Ann Larrer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Hancock Co Maine

14. Informant: Minnie Jellison
(Address) 716 E. Jefferson St. Boise Idaho

15. Filed 2-14-1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1929 to Feb 11th, 1929
that I last saw him alive on Feb 11th, 1929
and that death occurred, on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows: Senile dementia from softening of brain - acute nephritis -
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Senility -
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Bank, M. D.
2-13, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 2/14 1929.

20. Undertaker: Schreiber & McCann — Address: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64798

PLACE OF DEATH
County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 54
(No. 1122 Michigan Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Dollie Galloway.

(a) Residence. No. Wallowa, Oregon. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dick Galloway.

6. DATE OF BIRTH (month, day and year) Sept. 7th 1892

7. AGE Years	Months	Days	If LESS than 1 day, hours or min.
36	6	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Allen Co. Kansas.

PARENTS

10. NAME OF FATHER Bert Southwick.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Louisa Patterson.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind.

14. Informant Mrs. James Reagan.
(Address) Boise, Idaho.

15. Filed 2-15-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 13th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1929, to Feb 13, 1929
that I last saw h[illegible] alive on Feb 12, 1929
and that death occurred, on the date stated above, at 7:45 A.M.
The CAUSE OF DEATH* was as follows:
Acute Hypostatic Pneumonia
? (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 15 ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) D H Parker, M. D.
2/14/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	2/15/29 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 2

DO NOT WRITE IN THIS SPACE
State File No. 64799

County of Ada
City of Boise
Registration District No.
Primary Registration District No. 1004
Local Registrar's No. 55
(No. U.S.Veterans' Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Reed Christy

(a) Residence. No. 326 Forest Drive St. Coeur d'Alene, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. Reed Christy

6. DATE OF BIRTH (month, day and year) Sept.25,1887

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	4	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Mich.
(State or country)

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) unknown
(State or Country)
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) unknown
(State or Country)

14. Informant D.W.Herron
(Address) U.S.V.Hospital,Boise,Idaho

15. Filed 3/13/ 1929 Laura McDonagh
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 9, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19,1928, 19..., to Feb. 9,1929, 19...
that I last saw h im alive on Feb.9,1929, 19...
and that death occurred, on the date stated above, at 6:55 P. m.
The CAUSE OF DEATH* was as follows:
Tuberculosis,pulmonary,active

unknown (duration) ...yrs. ...mos. ...ds.
CONTRIBUTORY (Secondary) none
(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? XX
(Signed) H. B. BREWER, M. D.
MEDICAL OFFICER IN CHARGE
Feb.11,1929, 19... (Address) U.S. VETERANS' HOSPITAL BOISE, IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Mancelona, Mich.	
20. Undertaker W.McBratney	Address Boise,Idaho

RECEIVED MAR 6 1929

DEPAR F IDAHO
BUREAU PUBLIC WELFARE
ITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 64801

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 57

(No. St. Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John French Berry

(a) Residence. (Usual place of abode) No. 2719 Madison St. (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Jan. 23 - 1929

7. AGE Years Months Days 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Boise, Ida

PARENTS

10. NAME OF FATHER G. G. Berry

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Minnie Bell Davenport

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ky.

14. Informant G G Berry Boise (Address)

15. Filed 2 - 18 - 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 16 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia never treated Child (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) saw it as it was dieing (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) A. J. Coats, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. John's Cemetery Date of Burial 2/18 1929

20. Undertaker Schreiber & McCain Address Boise

French

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64802

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 58

(No. 1122 Lincoln Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME H. M. Shook

(a) Residence. No. 1122 Lincoln Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ida Shook.

6. DATE OF BIRTH (month, day and year) June 18th 1866

7. AGE Years	Months	Days	If LESS than 1 day, ——— hrs. or ——— min.
62	7	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wheeling, W. Va.

PARENTS

10. NAME OF FATHER Samuel Shook.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Martha Smith.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Va.

14. Informant S.T. Shook

(Address) Kimberly, Idaho.

15. Filed 2-15-, 1929 Paula McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 14th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13, 1929, to ———, 19—
that I last saw him alive on Feb. 13, 1929
and that death occurred, on the date stated above, at 6:55 PM m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H.M. Halverson, M. D.

2/15/29, 19— (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	2/16/29 19

20. Undertaker Wm. McBratney. Address Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64803

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 59

(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas D. Jones.

(a) Residence. No. 1219 Warren Street. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillie Jones.

6. DATE OF BIRTH (month, day and year): November 16th 1871

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
57	2	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Furniture Business.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Meigs Co. Ohio.

PARENTS

10. NAME OF FATHER: Peter Jones.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales.

12. MAIDEN NAME OF MOTHER: Anna R. Rosser.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales.

14. Informant: J. S. Feldhusen.
(Address): Twins Falls, Idaho.

15. Filed 2-13-1929 Paula McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 11th 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1929, to 2/11, 1929
that I last saw him alive on 2/11, 1929
and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:
Shock following operation for removal of Gall Bladder
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema of Gall Bladder (duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2/11/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Fred A. Mangler, M. D.

2/11/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 2/13/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64804

PLACE OF DEATH
County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 60
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Hortense Adams.

(a) Residence. No. Bristol Hotel, Boise, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	75			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mining Business.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Troy, N. Y.

PARENTS

10. NAME OF FATHER: John A. Pine.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown.
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Charles Nelson.
(Address): Sylvan Beach, McCall, Idaho.

15. Filed 2-23-29 Laula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 21st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1929, to Feb 21st, 1929
that I last saw her alive on Feb 21, 1929
and that death occurred, on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
& Chronic Nephritis
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Duodenal Ulcer & Nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory Tests
(Signed) E. H. Wahl, M. D.
2/25/29 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	2/23/29 19
20. Undertaker: Wm. McBratney.	Address: Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64805

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 61

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Herman Henry Taylor.

(a) Residence. No. 1415 Fort St. (Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Maud W. Taylor.

6. DATE OF BIRTH (month, day and year) Dec- 6- 1877

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51.	2	17.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Justice of Idaho
(b) General nature of industry, business, or establishment in which employed (or employer) Supreme Court
(c) Name of employer

9. BIRTHPLACE (city or town) Wisconsin
(State or country)

PARENTS

10. NAME OF FATHER Charles A. Taylor.
11. BIRTHPLACE OF FATHER (city or town) Wisconsin
(State or Country)
12. MAIDEN NAME OF MOTHER Elizabeth Crawford
13. BIRTHPLACE OF MOTHER (city or town) Wisconsin
(State or Country)

14. Informant Mrs. Maud W. Taylor
(Address) 1415 Fort St Boise Idaho

15. Filed 2-25-, 1929 Carla McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2- 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-10-, 1929, to 2-22-, 1929
that I last saw h- alive on 2-22-29, 19
and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Dyspepsia - Intestinal

in Origin (duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Ernest E. Faubaugh, M. D.

2-24-, 1929 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sandpoint Ida	Feb 27 1929
20. Undertaker	Address
Summers & Kube	Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64806

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1094

Local Registrar's No. 63

(No. St Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ada Norton Mussell

(a) Residence. No. 715 N. 7 St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

R

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Mussell

6. DATE OF BIRTH (month, day and year): May 7-1867

7. AGE: 61 Years, Months 9, Days 0. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Idaho Silver City Idaho

PARENTS

10. NAME OF FATHER: [illegible] Spromel Norton

11. BIRTHPLACE [illegible] (State or Country) [illegible] town): Penn

12. MAIDEN NAME OF MOTHER: Lucy Bash[illegible]

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Jacob Mussell

(Address) 715 N. 7 St Boise Idaho

15. Filed 2-18-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/5, 1929, to 2/7, 1929

that I last saw her alive on 2/7, 1929

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Exam.

(Signed) J. Earl Hill M. D.

2/8 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Caldwell Idaho

Date of Burial: Feb 9 1929

20. Undertaker: Summers & Kiefs

Address: Boise Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64807

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1904
Local Registrar's No. 62

(No. 1016 Hays Street Residence
~~(If death occurred in a hospital or institution, give its name instead of street and number.)~~

2. FULL NAME Catherine Morey

(a) Residence. No. 1016 Hays Street St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Homer A. Morey

6. DATE OF BIRTH (month, day and year) July 1 - 1853

7. AGE Years 75 Months 5 Days 13 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS
10. NAME OF FATHER Patrick Cremin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Island
12. MAIDEN NAME OF MOTHER Johanna Casey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Island

14. Informant Helen A. Strother
(Address) Boise Ida.

15. Filed 2-14-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ___, 1923, to Feb. 12, 1929
that I last saw her alive on Feb 12, 1929
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Hemiplegia

___ (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

___ (duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Chas. V. Gemmey, M. D.
___, 19___ (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. Johns Cemetery — Date of Burial 2/15 1928

20. Undertaker Schreiber & McCann — Address Boise, Ida

Informant, Funeral Director, Registrar and Medical Attendant, EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215). Address correspondence to State Bureau of Vital Statistics, Boise, Idaho.

United States Department of Commerce
Bureau of the Census

C O P Y

Certificate Of Death

STATE OF IDAHO

State File No. 64808
Local Reg. No.
Reg. Dist. No.

1. **PLACE OF DEATH:**
   (a) County Ada
   (b) City or town Boise
   (c) Street Address or R. F. D. No.
   (d) Death Occured Inside? Outside? city or town
   (e) Died in a Home Hospital Institution Other place
   (f) Name Hosp. or Inst. Stayed days
   (g) Lived in this county years months days
   Note. For a person residing in THIS county LESS than 1 year, give FORMER residence under item 2.

2. **Usual Residence of Deceased:** (Always fill in these)
   (a) State (b) County
   (c) City or town
   (d) Street Address or R.F.D. No.
   (e) Deceased lived Inside? Outside? city or town
   (f) Citizen of what country?
   (g) How long had deceased lived in Idaho? 3 years
   (h) Former residence (city, state) 4 Mos. 15 days

3. (a) **FULL NAME** WILLIAM GERRAL GORDON

3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Date of Birth (Month, Day, Year) August 11, 1886

8. AGE	Years	Months	Days	If less than 1 day
	42	6	9	hrs min.

9. Exact Occupation Farmer — Did this work for yrs.
10. Industry or Business — Date last worked
11. Birthplace Iowa (City or town) (State or foreign country)

Father
12. Name Unknown
13. Birthplace Unknown (City or town) (State or foreign country)

Mother
14. Maiden name Unknown
15. Birthplace Unknown (City or town) (State or foreign country)

16. Informant's **OWN** Signature D.W. Herron
and Address U.S.V. Hospital, Boise, Idaho

17. (a) (Burial, ~~cremation~~, removal) (b) Date thereof 2-24-29 (Month) (Day) (Year)
(c) Place: Morris Hill, Boise, Idaho

18. Funeral Director's **OWN** Signature McBratney
and Address Boise, Idaho

19. (a) Feb. 25, 1929 (Date received and filed) (b) Ruth McDonald (Registrar's signature)

MEDICAL CERTIFICATE OF DEATH

20. **DATE OF DEATH** (Month, Day, Year) February 20, 1929
at 8:50 o'clock P. M.

21. **I HEREBY CERTIFY**, That I attended deceased from October 5, 1925, to February 20, 1929
I last saw him alive on February 20, 1929; death is said to have occurred on the date and hour stated above.

Immediate Cause of Death: Tuberculosis of Meninges — Duration: Unknown

Due to Contributory: Tuberculosis, pulmonary, active.

Due to Secondary: Unknown

Other conditions (Include pregnancy within 3 months of death)

Where was disease contracted? Unknown
Name of operation None Date
Major finding
Finding of autopsy No autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to **EXTERNAL CAUSES**, also fill in the following: Accident? Suicide? Homicide?
Occurred 19 City, county, state where violence occurred
Place of Violence: Home Farm Industry
Public Place While at work?
Means of injury

23. Attendant's **OWN** Signature /s/ F.B. Brewer
Medical Officer in Charge U.S. Veterans Hospital
and Address Boise, Idaho Date Feb. 27 1929
(For additional space, use reverse side)

No._____

This is to Certify, That the following is a true and correct copy of a certificate of death, filed in the Bureau of Vital Statistics, Department of Public Welfare, as directed by Section 1644, Idaho Compiled Statutes, 1919.

Dec. 10, 1930 (Date)

By C K Macy Commissioner of Public Welfare.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64808

Local Registrar's No. 64

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. U.S. Veterans' Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME WILLIAM GERRAL GORDON

(a) Residence. No. 2110 Longmont St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 3 yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Virginia Gordon

6. DATE OF BIRTH (month, day and year) Aug. 11, 1886

7. AGE	Years	Months	Days	If LESS than 1 day,
	42	6	9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant D.W. Herron
(Address) U.S.V. Hospital, Boise, Idaho

15. Filed Feb. 25, 1929. Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1925, to Feb. 20, 1929
•that I last saw h im alive on Feb. 20, 1929
and that death occurred, on the date stated above, at 8:50P m.
The CAUSE OF DEATH* was as follows:

Tuberculosis of Meninges
unknown (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Tuberculosis, pulmonary, active
unknown (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F.B. Brewer U.S.Veterans' Bureau M.D.
Feb. 21, 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Feb.24,1929 19

20. Undertaker	Address
W. McBratney	Boise, Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 2

DO NOT WRITE IN THIS SPACE
State File No. 64809

PLACE OF DEATH
RECEIVED MAR 6 1929
County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 65
(No. 612 Pioneer Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Roy Edwin Shultz.

(a) Residence. No. 612 Pioneer St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) February 8th 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	17	----------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER David Shultz.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn.
12. MAIDEN NAME OF MOTHER Irene Pruett.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant David Shultz.
(Address) Boise, Idaho. Route #4

15. Filed 2/26/ 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 25th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8th, 1929, to Feb 25th, 1929
that I last saw him alive on Feb 25th, 1929
and that death occurred, on the date stated above, at 5:05 P. M.
The CAUSE OF DEATH* was as follows:
Convulsions caused by Congenital Heart Lesions.
(duration) yrs. mos. ds.
CONTRIBUTORY ----------
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Bauch M. D.
2/26/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 2/26/29 19

20. Undertaker: Wm. McBratney. — Address: Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64810

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1904
Local Registrar's No. 66
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Retzlaff

(a) Residence. No. 1523 Warm Springs Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Helen Retzlaff

6. DATE OF BIRTH (month, day and year) Nov-15-1879

7. AGE	Years	Months	Days	If LESS than 1 day,
	49	3	9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Florist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Charles Retzlaff
(Address) 1523 W. S. A. Boise Idaho

15. Filed 2-27-, 1929 Paula McDonnell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2- 26- 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1926, to 2-22-, 1929
that I last saw her alive on 2-26-29, 19
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:
Chronic Arthritis with
debilitation (Syphilitic)
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Cardiac
Debilitation (duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Germany
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) Ernest E. Parker M. D.
2-27-, 1929 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Mar 2 1929
20. Undertaker	**Address**
Summers & Kirk	Boise Idaho

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64811

PLACE OF DEATH
County of Ada
City of Boise
Registration District No.
Primary Registration District No.
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 67

2. FULL NAME Elizabeth T. Merriman
(a) Residence. No. 1 White Sandye Apt St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): July 2 1885
7. AGE: Years 42 | Months 7 | Days 24 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS
10. NAME OF FATHER: Charles A. Merriman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Emma C. Clegern
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Mrs. Emma C. Merriman
(Address) White Sandye apt. Boise Idaho
15. Filed 2/28, 1929 Paul M. McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 26 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 13, 1928 to Feby 26, 1929
that I last saw h alive on Feby 26, 1929
and that death occurred, on the date stated above, at 10, 9, m.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Same
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Nov 13 1928
Was there an autopsy? No
What test confirmed diagnosis? Microscopic findings
(Signed) Lauren H Chenoweth, M. D.
2/27, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pioneer Cemetery — Date of Burial: Feb. 28 1929
20. Undertaker: Summers & Rebe — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64812

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 68
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marie Louise Bayhouse
(a) Residence. No. 1010 O'Farrell St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 62 yrs. mos. ds. How long in U. S., if of foreign birth? 79 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: William Bayhouse

6. DATE OF BIRTH (month, day and year): Sept. 13 - 1832

7. AGE: Years 96 | Months 5 | Days 13 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hanau Schlesian Germany

PARENTS
10. NAME OF FATHER: John Bertram
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Marie Louise ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Henry Bayhouse
(Address) 1010 O. Farrell St. Boise

15. Filed 3/2/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Feb. 26, 1929
that I last saw her alive on Feb. 25 1929
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:
Hemiplegia Left Sided
Cerebral Hemorrhage
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Senility
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms
(Signed) Fred. A. Pilsenger M. D.
2/28, 1929 (Address) Boise Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pioneer Cemetery | Date of Burial: 2/28 1929

20. Undertaker: Schreiber & McCann | Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64813

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 69

(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cora Lee

(a) Residence. No. ..... St. Emmett, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): November 20th 1907

7. AGE: Years 21 | Months 3 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Waitres

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lost River, Butte Co Idaho

PARENTS

10. NAME OF FATHER: Jabez Lee

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rena Burdges

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant

(Address) Jabez Lee Emmett

15. Filed 3/1/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 28th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22nd, 1929, to Feb 28th, 1929 that I last saw her alive on Feb 27th, 1929 and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH* was as follows: Peritonitis following a G.C. infection

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 27th 29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

March 1st, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetry | Date of Burial: 3-1 1929

20. Undertaker: Schreiber McCann | Address: Boise Ida

Stewart

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64814

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 70

R

2. FULL NAME Clarence Orelando Ballou
(a) Residence. No. 1511 - 71 20 Street, St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Ballou
6. DATE OF BIRTH (month, day and year): January 18, 1866
7. AGE: Years 63, Months 1, Days 10. If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Druggist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS
10. NAME OF FATHER: Orelando Ballou
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: Mrs C.O Ballou
(Address) 1511 N. 20 st Boise Idaho
15. Filed 3/2/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 28 (Month) (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug, 1928 to Feb 28, 1929
that I last saw him alive on Feb 28, 1929
and that death occurred, on the date stated above, at 10.20 P.m.
The CAUSE OF DEATH* was as follows:
Auto accident Degeneration of 6th Dorsal vertebra. Hypertrophy of Prostate & Pyelitis (duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Uraemic poison & Pyelitis (duration) yrs. mos. 12 ds.
18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X ray & others
(Signed) T. N. Braxton M. D.
Mar 1, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Walla Walla Wash. Date of Burial: Mar 3 1929
20. Undertaker: Summers & Krebs Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED MAR 6 1929

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64815

County of Ada.
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 71
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John L. Montgomery.

(a) Residence. No. Boise, Idaho. R.#3 St.
(Usual place of abode)
Length of residence in city or town where death occurred. 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Montgomery.

6. DATE OF BIRTH (month, day and year) Feb. 5th 1881

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	0	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER John L. Montgomery.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.
12. MAIDEN NAME OF MOTHER Mary Bates.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Mrs. J. L. Montgomery.
(Address) Boise, Idaho. R.#3.

15. Filed 3/28/ 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 28th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1929, to Feb 28 1929
that I last saw h live on Feb 27 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Chronic Nephritis and uraemic condition

(duration) 2 yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Oedema
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) J. M. Bradshaw, M. D.
2/28/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	3/2/29 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

RECEIVED MAR 6 1929

PLACE OF DEATH

County of Ada.

City of

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64816

Registration District No. 8

Primary Registration District No. 2008

Local Registrar's No. 4

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ane Hansen

(a) Residence. No. 8 Miles N W of Boise, St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 31 - 1848

7. AGE Years 80 Months 1 Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Peterson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Chris Lillegard

(Address) R. D. H 2. Boise, Idaho

15. Filed 2-15-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1925, to Feby 15, 1929

that I last saw her alive on May, 1929

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows: Diabetes Mellitus

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary findings

(Signed) C. Dunn, M. D.

2/15, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery

Date of Burial Feb 18 1929

20. Undertaker Summers & Kuhs

Address Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 6 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64818

County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2008
Local Registrar's No. 5
(No.) Idaho Soldiers Home Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Archer

(a) Residence. No. Soldiers Home St. Saint Maries Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) — 1836

7. AGE	Years	Months	Days	If LESS than 1 day,
	93	0	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Veteran Idaho
(b) General nature of industry, business, or establishment in which employed (or employer) Indian Ware,
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant E J Burnet
(Address) Idaho Soldiers Home Boise Ida

15. Filed 2-20-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Feb 2, 1929
that I last saw him alive on Feb 17, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Myocardial Degeneration
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Bright's Disease
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis? Clinical Symptoms
(Signed) Fred A Fulbright, M. D.
2/29, 1929 (Address) Boise Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Feb 20 1929

20. Undertaker Summers & Hebe Address Boise Idaho

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64819

Registration District No. 8
Primary Registration District No. 2008
Local Registrar's No. 6

PLACE OF DEATH

County of Ada.
City of Near Meridian.
(No. I Mile East & 2¾ North of Meridian.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hubert Clay Mathews.

(a) Residence, No. I Mile E. & 2¾ Miles N. of Meridian.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of ----------
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 15th 1912.

7. AGE Years	Months	Days	If LESS than 1 day, ---------- hrs. or ---------- min.
16	9	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Long Valley

PARENTS

10. NAME OF FATHER Clyde Mathews.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Hester Young.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Mrs. Bruce Montgomery.
(Address) Boise, Idaho.

15. Filed 2-26-1929 Lula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 14th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1929, to Feb 14, 1929
that I last saw him alive on Feb. 14, 1929
and that death occurred, on the date stated above, at 10:40PM m.
The CAUSE OF DEATH* was as follows:
Diabetic Coma

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. F. Neal, M. D.
2-16, 1929 (Address) Meridian, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Joplin Cemetery.	2/17/29 19
20. Undertaker Wm. McBratney.	Address Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64820

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2008

Local Registrar's No. 7

(No. Boise, Idaho. Route #I)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bertram Wiggins.

(a) Residence. No. Boise, Idaho. Route #I. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) October 21st 1876

7. AGE: Years 52, Months 4, Days 0. If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Truck Driver.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10. NAME OF FATHER: O. A. Wiggins.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Vermont.

12. MAIDEN NAME OF MOTHER: Mary A. Bisbee.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New York.

14. Informant: Mrs. V. B. Rogers.

(Address) Boise, Idaho. Route #I.

15. Filed 2-25, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 21st 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ----- ----------, 19--, to ----------, 19--

~~that I last saw h--- alive on~~ ----------, 19--

~~and that~~ death occurred, on the date stated above, at 8:15A.M m.

The CAUSE OF DEATH* was as follows:

Suicide. Shot himself in the right temple, bullet coming out in forehead above left eye. He used a 32 Automatic pistol. Worry and financial troubles were apparently the cause.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

No Inquest held.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W McBratney, Coroner, ~~M. D.~~

2/22/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery

Date of Burial: 2/23/29, 19

20. Undertaker: Wm. McBratney.

Address: Boise, Ida.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64821

PLACE OF DEATH
County of Ada
City of Orchard

Registration District No. 8
Primary Registration District No. 2008
Local Registrar's No. 8
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kenneth Ray Morgan

(a) Residence. No. Orchard Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 28-1928

7. AGE	Years	Months	Days	If LESS than 1 day,
		7	1	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho

PARENTS

10. NAME OF FATHER Lynn R. Morgan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Malad Ida
12. MAIDEN NAME OF MOTHER Karma Whitaker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Downey Idaho

14. Informant Lynn R Morgan
(Address) Orchard Idaho

15. Filed 3/27, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1929, to Feb 22, 1929
that I last saw him alive on Feb 22, 1929
and that death occurred, on the date stated above, at 9 A m.
The CAUSE OF DEATH* was as follows: Was treating this case as a feeding case, which service bore no direct relation to fatal illness. Was called at 9 A.M. March 1st. Child dying at home in Orchard, Idaho before my arrival. Cause of death pulmonary atelectasis (duration) 3 yrs. 7 mos. 1 ds.
CONTRIBUTORY (Secondary) (duration) yrs. ds.
18. Where was disease contracted if not at place of death? Not known
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis? none
(Signed) Harrison Fremaine, M. D.
MAR 1 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Downey Ida	Mar 3 1929
20. Undertaker	Address
Summers & Kibe	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64822

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 8

Local Registrar's No. 9

(No. Idaho State Penitentiary.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME J. V. Charters.

(a) Residence. No. State Penitentiary St.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 2 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Convict. (Farmer)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant T. N. Cribbins.

(Address) Boise, Idaho.

15. Filed 3/1/ 1929 Laura M. Donald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 27th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. , 1925, to Feb. 27, 1929

that I last saw h me alive on Feb 27, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hemorrhage. cerebral

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer Duodenum & Pancreas

(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? 8

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Post Mortem

(Signed) C. V. Parker, M. D.

2/28/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
State Penitentiary Cemetery.	3/1/29 19

20. Undertaker Wm. McBratney Address Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 26 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64824

PLACE OF DEATH

County of Ada.

City of Near Star, Idaho.

Registration District No. 9-10

Primary Registration District No. 9-10

Local Registrar's No. 1

(No. One Mile East of Star, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Bach.

(a) Residence. No. One Mile East of Star. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara Bach.

6. DATE OF BIRTH (month, day and year) January 19th 1870

7. AGE: 59 Years, Months: 0, Days: 20. If LESS than 1 day, ~~hrs. or~~ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Rancher.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Deep Creek, Utah.

PARENTS

10. NAME OF FATHER: John Bach.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Mary Worthington.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Mrs. Clara Bach.
(Address): Star, Idaho.

15. Filed 2-14, 1929. Dorrey Jackson, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 9th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jany 10, 1929, to Feby 9, 1929, that I last saw him alive on 2-9, 1929, and that death occurred, on the date stated above, at 2:15 A.M. m.

The CAUSE OF DEATH* was as follows:

Empyema

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Flu — Pneumonia

(duration) yrs. mos. 12 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

2/11/29, 19 (Address) Star, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Cemetery. Date of Burial: 2-14-29 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 13 1929

PLACE OF DEATH

County of Ada

City of Meridian

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64825

Registration District No. 11

Primary Registration District No. 2003

Local Registrar's No. 1

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas D Matlock

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years X; Months 2; Days 16; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Meridian Id.

PARENTS

10. NAME OF FATHER: J. W. Matlock

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Lulu Heard

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Oregon

14. Informant: James W Matlock
(Address) Meridian Id.

15. Filed 1-6, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1929 to Jan 4, 1929 that I last saw him alive on Jan 4, 1929 and that death occurred, on the date stated above, at 2:30 p m.

The CAUSE OF DEATH* was as follows: Acute Intestinal Flu

10 hours (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ✓

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) [signature] M. D.

Jan 6, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery — Date of Burial: Jan 6 1929

20. Undertaker: W S Mather — Address: Meridian Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64826

PLACE OF DEATH
County of Ada
City of Meridian
Registration District No. 11
Primary Registration District No. 2003
(No.)
Local Registrar's No. 21
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isadora-Jane-Powell

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Merried

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of George Powell

6. DATE OF BIRTH (month, day and year) March-17th-1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	10	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Adam McAuley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Sarrah Coleman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New Your State

14. Informant Mary French
(Address) Meridian Idaho

15. Filed 2-5, 1929 J. F. Neal
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feburary (Month) 4th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/17, 1928, to Febr. 4, 1929
that I last saw h[er] alive on 11/16, 1929
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Cancer Stomach
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At Place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis
(Signed) J. F. Neal, M. D.
2-5, 1929 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Cemetery	Feb 6th 1929

20. Undertaker W. S. Mathes
Address Meridian Id

RECEIVED FEB 16 1929

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64827

Local Registrar's No. 5474

2. FULL NAME LOWELL F. DUNN

(a) Residence. No. TYHEE (Usual place of abode) St. IDAHO (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 1, 1924

7. AGE	Years	Months	Days	If LESS than 1 day,
	4	8	1	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) TYHEE

PARENTS

10. NAME OF FATHER SAMUEL A DUNN

11. BIRTHPLACE OF FATHER (city or town) (State or Country) COLLEGE UTAH

12. MAIDEN NAME OF MOTHER ETHEL HILL

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) SMITHFIELD, UTAH

14. Informant SAMUEL A DUNN

(Address) TYHEE

15. Filed 1-2, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JAN (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-2, 1928, to 1-2, 1929

that I last saw h[illegible] alive on 1-2, 1928

and that death occurred, on the date stated above, at 1.45 m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 20 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D C Ray M. D.

1-2, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
MOUNTAIN VIEW	
20. Undertaker ARTHUR W. HALL	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64828

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 428 E. Lovejoy)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5475

2. FULL NAME Frederike Caroline Kahn
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) Dec. 14-1840
7. AGE Years 88 Months — Days 23 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeper retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Johann Westphal
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Maria E. Graf
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Matilda Edwards
(Address) Pocatello, Ida.
15. Filed Jan 5, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 5 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 28, 1928, to Jan 5, 1929
that I last saw her alive on Jan 1, 1929
and that death occurred, on the date stated above, at 3 a. m.
The CAUSE OF DEATH* was as follows:
Hemiplegia
..... (duration) ..... yrs. 1 mos. — ds.
CONTRIBUTORY (Secondary) age
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? physical Exam
(Signed) J. H. [signature], M. D.
1/5/29 19 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Analaska Wisconsin
Date of Burial: Jan 7 1929
20. Undertaker: McHon Undt Co.
Address: Pocatello

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64829

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5476
(No. 531 So. Garfield St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Edward Garner

(a) Residence. No. ... St. ...
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
7	1	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS
10. NAME OF FATHER Henry E. Garner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pocatello Idaho
12. MAIDEN NAME OF MOTHER Marie Potts
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas.

14. Informant Henry E. Garner
(Address) Pocatello Idaho

15. Filed 1/5, 1929 J. W. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 6.45 a. m.
The CAUSE OF DEATH* was as follows:
Meningitis
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Mastoiditis
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? ... Date of ...
Was there an autopsy? ...
What test confirmed diagnosis? ...
(Signed) H. L. McHan Coroner M. D.
Jan 5, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello Ida.	Jan 7 1929
20. Undertaker	Address
McHan Undt Co.	Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64830

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5477

PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 315 North 3rd St)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Malvie Payton

(a) Residence. No. 315 North 3rd St St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 25th 1875

7. AGE	Years	Months	Days	If LESS than 1 day,
	53	—	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Louisville
(State or country) Ky.

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant Frank Payton
(Address) Pocatello Idaho

15. Filed 1-7, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11, 1928, to 1-2, 1929
that I last saw her alive on 1-1, 1929
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Mitral insufficiency
(duration) yrs. 1 mos. — ds.
CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes —
Did an operation precede death? no Date of none
Was there an autopsy? no
What test confirmed diagnosis? Physical Exam
(Signed) H. H. Lyon, M. D.
1-7, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View Cemetery	1-6- 1929
20. Undertaker	Address
Schumacher & Beasley	City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64831

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 29
Primary Registration District No. 2161
(No. McCAMMON)
Local Registrar's No. 5478

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ERNEST I. ROMERILL

(a) Residence. No. Mc. CAMMON St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) DEC. 20 1907

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	21	0	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work FARMER
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) McCAMMON

PARENTS

10. NAME OF FATHER C.A. ROMERILL
11. BIRTHPLACE OF FATHER (city or town) (State or Country) UTAH
12. MAIDEN NAME OF MOTHER ANNA NORTON
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UTAH

14. Informant C.A. ROMERILL
(Address) McCAMMON

15. Filed 1/12, 1929 J.H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JAN 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Gun Shot Wound
Jiw grain.
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) accidental discharged
Shot gun
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____
(Signed) H. L. McKan Coroner M. D.
Jan 11, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
McCAMMON	
20. Undertaker ARTHUR W HALL	Address POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64832

PLACE OF DEATH

County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5479
(No. 538 NO 6th AVENUE)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME WILLIAM T. BRIDGES

(a) Residence. No. 538 No. 6th AVE St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ ELIZABETH STINGER

6. DATE OF BIRTH (month, day and year) AUG 6

7. AGE	Years	Months	Days	If LESS than 1 day,
	57	5	5	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work RETIRED

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ARKANSAW

PARENTS

10. NAME OF FATHER GEORGE T. BRIDGES

11. BIRTHPLACE OF FATHER (city or town) (State or Country) UNOWN

12. MAIDEN NAME OF MOTHER MARANDA-BRIDGES

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UNOWN

14. Informant MRS. W.T. BRIDGES
(Address) 538 - NO. 6th AVE

15. Filed 1-12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JANUARY 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-18, 1928, to 1-10, 1929
that I last saw ~~him~~ alive on 1-9, 1929
and that death occurred, on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows: Cardiac Renal disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Typical
(Signed) [signature], M. D.
1-12, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW	JAN 12 1929
20. Undertaker	Address
ARTHUR W HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64833

PLACE OF DEATH
County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5480
(No. 1154 So. 5TH AVE.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME MAHLON D. ATKIN

(a) Residence. No. 1154 So. 5TH AVENUE St.
(Usual place of abode)
Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of ANNA RANDOLPH

6. DATE OF BIRTH (month, day and year) JUNE 6 1854

7. AGE	Years	Months	Days	If LESS than 1 day,
	74	7	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work RETIRED
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) INDIANA

PARENTS

10. NAME OF FATHER MAJOR ATKIN
11. BIRTHPLACE OF FATHER (city or town) (State or Country) OHIO
12. MAIDEN NAME OF MOTHER BETSY BANKS
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) OHIO

14. Informant MRS MAHLON D ATKIN
(Address) 1154 So. 5TH AVE.

15. Filed 1-12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
JAN. (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-27 1928, to date, 19
that I last saw h alive on 1-2-29, 1928
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Senile debility
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 12 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) [signature] M. D.
1/12, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW	JAN 12 1929
20. Undertaker	Address
ARTHUR W HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 16 1929

STATE OF IDAHO Howard
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64834

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5481

PLACE OF DEATH

County of Bannock

City of Pocatello

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Amelia Mota

(a) Residence. No. ..... St. .....

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	SP	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Carl George

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Henrietta Freese

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs Maurice Rassiter

(Address) 1358 So 4th Ave

15. Filed 1/16 1929 W Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1929 to Jan 15 1929
that I last saw her alive on Jan 14 1929
and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) William E Howard M. D.

Jan 16 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Mt View Cem	
20. Undertaker	Address
H. L. McHan	Pocatello

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64835

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5482

PLACE OF DEATH
County of Bannock
City of Pocatello
(No.) Pocatello General Hospital
(If death occurred in hospital or institution, give its name instead of street and number.)

2. FULL NAME Martha Ellen Hopper

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Samuel E. Hopper

6. DATE OF BIRTH (month, day and year): Oct 30th 1876

7. AGE: Years 52 | Months 2 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): " "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Samuel E. Hopper
(Address): Pocatello Idaho Box 481

15. Filed 1-16, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 10th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1929, to Jan 10, 1929
that I last saw her alive on Jan 10, 1929
and that death occurred, on the date stated above, at 5 20 p.m.

The CAUSE OF DEATH* was as follows:
Paralytic Ileus following Operation
(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) John J. Card M. D.
Jan 10, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mt Moriah Cem — Date of Burial: 1/13 1929

20. Undertaker: H. L. McClain — Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64836

1. PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St Anthonys Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5483

2. FULL NAME Rachel Bruce
(a) Residence. No. 655 West Center St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE 55 Years Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS
10. NAME OF FATHER John Weir
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Unknown Young
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Rachel Jacobsen
(Address) 655 West Center
15. Filed 1/17, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 15/29 19
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 11/5, 1928, to 1/15, 1929
that I last saw her alive on 1/14, 1929
and that death occurred, on the date stated above, at 1:10 a.m.
The CAUSE OF DEATH* was as follows:
Shock with dilated heart following abdominal operation 1/14/29
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Nephritis - Mitral lesion
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Don't know
Did an operation precede death? Yes Date of 1/14/29
Was there an autopsy? no
What test confirmed diagnosis? Usual
(Signed) H. C. Irwin, M. D.
1/16, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Over

19. Place of Burial, Cremation, or Removal | Date of Burial 19
20. Undertaker H. L. McHan | Address Pocatello

Public Health Adviser
Food and Drug Inspection
Bacteriological Laboratory
Chemical Laboratory
Sanitary Engineer
Bureau of Child Hygiene
Vital Statistics

DAVID BURRELL, Commissioner

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
Lava Hot Springs, Lava
Idaho Soldiers' Home, Boise
Northern Idaho Sanitarium, Orofino
State School & Colony, Nampa

H. C. BALDRIDGE, Governor

March 19, 1929.

Dr. H. C. Irwin,
Pocatello, Idaho.

Re: 64836

Dear Doctor:

In order to complete the death certificate of RACHEL BRUCE who died at St. Anthony's Hospital on January 15, 1929, will you kindly advise whether she was

SINGLE, MARRIED or DIVORCED.

An addressed stamped envelope is enclosed for your convenience in returning this letter with the desired information.

Respectfully yours,

C. K. Macey

C. K. Macey,
State Registrar.

Operation Chr G.B. & appendix - Chest neg for fluid Etc - Irregular heart mitral murmur. Dyspnoea on table - which gradually increased to a cyanosis - Probable cause of death Respiratory failure dilatation heart - oedema lungs -

Married

H. C. Irwin

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64837

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 1213 N. Hayes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5484

2. FULL NAME Jacob E. Griffiths
(a) Residence. No. 1213 N. Hayes St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): March 4, 1855

7. AGE: Years 73 | Months 10 | Days 17 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Virginia

PARENTS
10. NAME OF FATHER: Samuel Griffiths
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Rebecca Griffiths
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14. Informant: A. H. Griffiths
(Address) Pocatello, Ida

15. Filed Jan 21, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 20 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to Jan 21, 1929
that I last saw him alive on Jan 21, 1929
and that death occurred, on the date stated above, at 12:30 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Joshua Alan
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A. R. Groom, M. D.
1/22, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Idaho | Date of Burial: Jan 22 1929

20. Undertaker: McHan Undt Co. | Address: Pocatello

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64838

PLACE OF DEATH
County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 2161
(No. 507 - NORTH GARFIELD)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 5485

2. FULL NAME LOUISE EMMA ADDY

(a) Residence. No. 507 - N - GARFIELD St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	WIDOW

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ROBERT ADDY

6. DATE OF BIRTH (month, day and year) FEB. 5, 1868

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work RETIRED
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) UTAH

PARENTS
10. NAME OF FATHER ALFRED CLARK
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ENGLAND
12. MAIDEN NAME OF MOTHER HANNAH WAKEFIELD
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ENGLAND

14. Informant MRS. ELLEN IVY
(Address) WYOMING

15. Filed 1-22, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JAN. (Month) 20, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-20, 1929, to 1-20, 1929, that I last saw h[illegible] alive on 1-20, 1929, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? NO Date of —
Was there an autopsy? NO
What test confirmed diagnosis? I saw her die

(Signed) [signature] M. D.
1-22, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW	JAN 23, 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64839

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5486

PLACE OF DEATH

County of BANNOCK
City of POCATELLO
(No. GENERAL HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ROY ALLRED

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) DEC 13 1883

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45	1	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work FIREMAN AND ENGINEER
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) AMERICAN FALLS IDA.

PARENTS

10. NAME OF FATHER CHAS. W. ALLRED
11. BIRTHPLACE OF FATHER (city or town) (State or Country) UTAH
12. MAIDEN NAME OF MOTHER EMMA WILLIAMS
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) PENNSYLVAINA

14. Informant LEW ALLRED
(Address) INKOM

15. Filed 1/22, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JANUARY 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-17, 1929, to 1-19, 1929
that I last saw h~~im~~ alive on 1-19, 1929
and that death occurred, on the date stated above, at 5a m.
The CAUSE OF DEATH* was as follows: Myocarditis -

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. H. Young M. D.
1-22, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
MOUNTAIN VIEW	
20. Undertaker ARTHUR W HALL	Address POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

FILED FEB 16 1929

DO NOT WRITE IN THIS SPACE
State File No. 64840

County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5487
(No. ST. ANTHONY HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME KENNETH LAVON YORGENSEN
(a) Residence. No. 1047 N SHOSHONE St. BASALT IDAHO
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) OCT 7 28

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	4	12	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work AT HOME
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) BASALT

PARENTS

10. NAME OF FATHER LAVON D. YORGENSEN
11. BIRTHPLACE OF FATHER (city or town) (State or Country) BASALT
12. MAIDEN NAME OF MOTHER GLADYS L JOHNSON
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) BASALT

14. Informant LAVON YORGENSEN
(Address) BASALT

15. Filed 1/23, 1929 J. C. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JAN 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19, 1929, to Jan 20, 1929
that I last saw him alive on Jan 20, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis? Physical Exam

(Signed) O. F. Teall, M. D.
1/23, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
BASALT CEMETERY	19
20. Undertaker	Address
ARTHUR W HALL	POCATELLO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64841

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5488

(No. GENERAL HOSPITAL)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME KENNETH EUGINE ADAMS

(a) Residence. No. 232 WEST CARTER St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE

4. COLOR OR RACE: WHITE

5. Single, Married, Widowed, or Divorced (write the word): SINGLE

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) NOVEMBER 24 1928

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
0	1	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: INFANT

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) POCATELLO IDAHO

PARENTS

10. NAME OF FATHER THOMAS ADAMS

11. BIRTHPLACE OF FATHER (city or town) (State or Country) RHODE ISLAND

12. MAIDEN NAME OF MOTHER ETHEL IRENE WALTON

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) WYOMING

14. Informant THOMAS ADAMS

(Address) 232 W. CARTER

15. Filed 1-23, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JANUARY 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1929, to Jan 21st, 1929

that I last saw him alive on Jan 21, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Pyloric Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Exhaustion

Post Op. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Congenital

Did an operation precede death? Yes Date of Jan 20/29

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. & Rep. & Op. Vision

(Signed) [signature], M. D.

Jan 23, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: MOUNTAIN VIEW

Date of Burial: 19

20. Undertaker: ARTHUR W HALL

Address: POCATELLO

FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64842

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. N 3RD AVE)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5489

2. FULL NAME WESLEY GILL
(a) Residence. No. N 3RD AVE St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: NEGRO
5. Single, Married, Widowed, or Divorced (write the word): UNKOWN

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) UNKNOWN

7. AGE Years: ABOUT 40 | Months | Days | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) UNKNOWN

PARENTS
10. NAME OF FATHER UNKNOWN
11. BIRTHPLACE OF FATHER (city or town) (State or Country) UNKNOWN
12. MAIDEN NAME OF MOTHER UNKNOWN
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UNKNOWN

14. Informant NONE
(Address)

15. Filed 1/24, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JAN. 21 OR 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929, to Jan 3, 1929
that I last saw him alive on Jan 3, 1929
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows: Cardio Renal disease
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of —
Was there an autopsy? No —
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
1/24, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: MOUNTAIN VIEW
Date of Burial: JAN. 24 1929

20. Undertaker: ARTHUR W HALL
Address: POCATELLO

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Dr. 942

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64843

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2761
(No. 525 N. Hayes)
Local Registrar's No. 5490
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alice Atkinson

(a) Residence. No. 525 N. Hayes St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Mar 16-1858

7. AGE: Years 70 | Months 10 | Days 6 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Housewife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS
10. NAME OF FATHER: Andrew Entericil
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Simmons
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Joseph Atkinson
(Address) Pocatello Idaho

15. Filed 1/24, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 21, 1929
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan 9, 1929, to Jan 21, 1929
that I saw h[illegible] alive on Jan 20, 1929
and that death occurred, on the date stated above, at 1 A m.
The CAUSE OF DEATH* was as follows:

Influenza
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam.

(Signed) O. F. Cecil, M. D.
Jan 24, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: Jan 25 1929
20. Undertaker: Schumacher & Hawley — Address: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Dr. Roof

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64844

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 216
(No. 1132 N. 8th)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5491

2. FULL NAME Mrs Minnie Lewis
(a) Residence. No. 1132 N. 8th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of — —

6. DATE OF BIRTH (month, day and year) Jan 22 - 1869

7. AGE Years 59 Months 11 Days 28 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER Clement H. Hughes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Mary J. Lewis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Mrs Mary Fister
(Address) Pocatello Idaho

15. Filed 1-24, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1929, to Jan 20, 1929
that I last saw her alive on Jan 20, 1929
and that death occurred, on the date stated above, at 6:30 P.m.
The CAUSE OF DEATH* was as follows:
Facial Erysipelas
(duration) yrs. mos. 20 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. J. Roof M. D.
Jan 20, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View
Date of Burial Jan 23 1929

20. Undertaker Schumacher & Beasley
Address City

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64845

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 21
Primary Registration District No. 2166
(No. 660 E. Center)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5492

2. FULL NAME Carmellia Dalpino

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): June 7th 1878

7. AGE: Years 50 | Months 7 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10. NAME OF FATHER: Paul Perotti
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Italy
12. MAIDEN NAME OF MOTHER: Amelia Bernadine
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy

14. Informant: Ralph Gates Jr
(Address): Pocatello Idaho

15. Filed Jan 24, 1929 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 19th (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929 to Jan 19, 1929
that I last saw her alive on Jan 19, 1929
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH was as follows:
Chronic Valvular Heart Disease

..... (duration) 6 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Pulmonary Oedema
..... (duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) William F. Howard M. D.
Jan 24 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: Jan 23 1929
20. Undertaker: Schumacher & Beasley — Address: City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64846

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello Gen. Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5493

2. FULL NAME Nancy Louise Flint.
(a) Residence. No. 556 W. Greely St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) May 30, 1923
7. AGE Years: 5 Months: 7 Days: 25 If LESS than 1 day ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Pocatello Ida

PARENTS
10. NAME OF FATHER: H. R. Flint
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Minnesota
12. MAIDEN NAME OF MOTHER: Ruth Muir
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Minn.

14. Informant: H. R. Flint
(Address): Pocatello, Idaho
15. Filed Jan 24 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1929, to Jan 23, 1929
that I last saw her alive on Jan 23, 1929
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Pneumococcic Laryngitis.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 1/23/29
Was there an autopsy? No. Tracheotomy
What test confirmed diagnosis?
(Signed) C. P. Lawson M. D.
Jan 24, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Idaho Date of Burial: Jan 27 1929
20. Undertaker: McHan Undertaking Co. Address: Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64847

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5494

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sophie Adelaide Scott
(a) Residence. No. 821, So. 4th ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Nov 14, 1851

7. AGE Years 77. Months 2 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House keeper
(b) General nature of industry, business, or establishment in which employed (or employer) for daughter
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Provo Utah

PARENTS
10. NAME OF FATHER Hyram Hoops
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pensylvania
12. MAIDEN NAME OF MOTHER Eliza J. Redfield
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Ethel Taylor
(Address) Pocatello, Idaho

15. Filed Jan. 24, 1929 H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Jan 23, 1929
that I last saw h..... alive on ..... 19.....
and that death occurred, on the date stated above, at 8 20 a m.
The CAUSE OF DEATH* was as follows:
Raynaud's disease
(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. W. Brothers M. D.
Jan 24, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grace Idaho
Date of Burial: Jan 26 1929

20. Undertaker: McHan Undt Co
Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64848

Local Registrar's No. 5495

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No.
(No. 434 W. Hayes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William A. Wadeal

(a) Residence. No. 434 W. Hayes st.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 1st 1857

7. AGE: Years 71 | Months 6 | Days 26 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): at School
(c) Name of employer: Building

9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS

10. NAME OF FATHER: William Wadeal
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Michigan
12. MAIDEN NAME OF MOTHER: Ellen Mc. Nabb
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Mrs Mary Wadeal
(Address) 434 W. Hayes

15. Filed 1-28, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) — 27 (Day) — 29 (Year) 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1929, to Jan 27, 1929
that I last saw h— alive on Jan 27, 1929
and that death occurred, on the date stated above, at 9 1/5 m.
The CAUSE OF DEATH* was as follows:
Mitral insufficiency

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of —
Was there an autopsy? no —
What test confirmed diagnosis? heart auscultation

(Signed) W. H. Lyons, M. D.
1-27, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: Jan 31 1929
20. Undertaker: Schumacher & Beasley — Address: City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64849

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 745 N. Hayes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5496

2. FULL NAME Samuel A. Wichline

(a) Residence. No. 745 N. Hayes St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR ~~OR RACE~~ White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 17-1841

7. AGE Years 87 Months 5 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS
10. NAME OF FATHER Samuel Wichline
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Taylor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Philo B. Wichline
(Address) Los Angeles Cal

15. Filed 1/30, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1929, to Jan 27, 1929
that I last saw him alive on Jan 26, 1929
and that death occurred, on the date stated above, at 8 a m.
The CAUSE OF DEATH* was as follows:
Appoplexy
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Senility General
arterio sclerosis (duration) ? yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) O. Hall, M. D.
, 19 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View
Date of Burial Jan 29 1929

20. Undertaker Schumacher Beasley
Address City

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64850

PLACE OF DEATH
County of Bannock
City of

Registration District No. 28
Primary Registration District No. 2161
(No. 531 So. Garfield)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5497

2. FULL NAME Jeanne M. Garner
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): May 10, 27
7. AGE: Years 1, Months 8, Days 18, If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho

PARENTS
10. NAME OF FATHER: H. E. Garner
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pocatello
12. MAIDEN NAME OF MOTHER: Marie Potts
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kansas

14. Informant: H. E. Garner
(Address): Pocatello, Ida
15. Filed Jan 30, 1929 J. B. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 1-22, 1929, to 1-27, 1929
that I last saw her alive on 1-27, 1929
and that death occurred, on the date stated above, at 9:20 P. m.
The CAUSE OF DEATH* was as follows:
Empyema
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): pneumonia
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 1-22-29
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) D. C. Ray, M.D.
Jan 30, 1929 (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Idaho
Date of Burial: Jan 30 1929
20. Undertaker: McHan Underlaking Co.
Address: Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64851

PLACE OF DEATH
County of Bannock
City of Lubsom

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5498

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Pearl Wenonah Fowler

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years | Months | Days: 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lubsom

PARENTS

10. NAME OF FATHER: Ross B. Fowler
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kaysville Idaho
12. MAIDEN NAME OF MOTHER: Ravella Tillman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Clarkston Idaho

14. Informant: Ross B. Fowler
(Address): Lubsom Idaho

15. Filed 1/31, 1929 J. F. Toomey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1929, to Jan 31, 1929
that I last saw her alive on Jan 31, 1929
and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:
Premature, birth at 7 mo.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Albuminuria in mother (duration) ..... yrs. 7 mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) J. F. Miller, M. D.
19 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lubsom Cemetery — Date of Burial: Jan 31 1929
20. Undertaker: Ross B. Fowler — Address: Lubsom Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64852

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5499
(No. 727 NO. GARFIELD)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME KATE BESWICK TERRY
(a) Residence. No. 727 NO. GARFIELD St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): MARRIED
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: GEORGE A TERRY
6. DATE OF BIRTH (month, day and year): FEBRUARY 3 1875
7. AGE: Years 54, Months 0, Days 4. If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: HOUSEWIFE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): NEW YORK

PARENTS
10. NAME OF FATHER: OTIS BESWICK
11. BIRTHPLACE OF FATHER (city or town) (State or Country): NEW YORK
12. MAIDEN NAME OF MOTHER: VIOLA SHERMAN
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): NEW YORK

14. Informant: GEORGE A. TERRY
(Address) 727 NORTH GARFIELD
15. Filed 2/8, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: FEBRUARY 6 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1929, to Feb 6, 1929
that I last saw her alive on Feb 5, 1929
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows: Peritonitis Fallen Rupture Gall Bladder with Stones
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Gall Stones
~~[illegible]~~ pronounced [illegible]
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phys. Exam. & History
(Signed) O. F. Call, M. D.
2/7, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: MOUNTAIN VIEW
Date of Burial: FEB. 8 1929
20. Undertaker: ARTHUR W. HALL
Address: POCATELLO

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64853

Local Registrar's No. 5500

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

Registration District No. 28

Primary Registration District No. 2161

(No. 1122 N. HARRISSON)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME EPHRAIM THOMAS

(a) Residence. No. 1122 N. HARRISSON St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	WIDOWED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of MARGARET N. THOMAS

6. DATE OF BIRTH (month, day and year) JULY 11 1855

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
73	6	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work RETIRED

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) BRIGHAM CITY UTAH

PARENTS

10. NAME OF FATHER REESE THOMAS

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ENGLAND

12. MAIDEN NAME OF MOTHER MARY

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ENGLAND

14. Informant MRS. D. L. BOLING BROKE

(Address) MALAD IDAHO

15. Filed 2/9, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH FEBRUARY 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1-, 1929, to Feb 8, 1929, that I last saw h[illegible] alive on Feb 8, 1929, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis - Pneumonia

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Malad Idaho

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

2/9, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MALAD IDAHO	FEB. 12 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FEB 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64854

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5501

PLACE OF DEATH
County of BANNOCK
City of POCATELLO
(No. GENERAL HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME MIDA JENSEN CLARK

(a) Residence. No. BLACKFOOT IDAHO St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of MARION CLARK

6. DATE OF BIRTH (month, day and year) NOV. 21 1908

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	20	2	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work HOUSE WIFE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) GREEN RIVER Wyo.

PARENTS

10. NAME OF FATHER JENS P JENSEN
11. BIRTHPLACE OF FATHER (city or town) (State or Country) DENMARK
12. MAIDEN NAME OF MOTHER ANE. K. JENSEN
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) DENMARK

14. Informant MARION CLARK
(Address) BLACKFOOT IDAHO

15. Filed 2/11, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH FEBRUARY (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1929, to Feby 11, 1929, that I last saw h[er] alive on Feby 10, 1929, and that death occurred, on the date stated above, at n a m.

The CAUSE OF DEATH was as follows:
Peritonitis (Pneumococcic) (Primary)
(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Blackfoot Idah
Did an operation precede death? Yes Date of Jan 5th 29
Was there an autopsy? Yes
What test confirmed diagnosis Bacteriologic Study

(Signed) Thos F Clement M. D.
Feby 11, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
THOMAS IDAHO	
20. Undertaker	Address
ARTHUR W HALL	POCATELLO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64855

PLACE OF DEATH
County of Bannock
City of Bancroft

Registration District No. 84
Primary Registration District No. 2161
(No.)

Local Registrar's No. 143

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Eva Jensen

(a) Residence. No. ( ) St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb. 6-29

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bancroft Ida

PARENTS

10 NAME OF FATHER Parley P. Jensen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Utah

12 MAIDEN NAME OF MOTHER Florence Ruby Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah

14 Informant Mrs. Parley P. Jensen
(Address) Bancroft Ida

15 Filed Feb-28, 1929 Mrs. G G. Fet. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 9 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb-6-, 1929, to Feb 9-, 1929, that I last saw her alive on Feb-9-, 1929, and that death occurred, on the date stated above, at EP. m.

The CAUSE OF DEATH* was as follows:
Premature birth
Bronchial Pneumonia
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) G. G. Fet, M. D.
Feb 28, 1929 (Address) Bancroft

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19. RECEIVED FEB 19 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Swan Lake

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83

Primary Registration District No. 2160

(No. ..... , ... St.)

File No. 64858

Registered No. 102

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elias Busenbark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: August (Month) 30 (Day) 1881 (Year)

7. AGE: 47 Yrs. 5 Mos. mo ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Section Foreman

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Beaver Dam, Utah.

10. NAME OF FATHER: Munroe Busenbark

11. BIRTHPLACE OF FATHER (State or Country): Sorah ~~N. S.~~ UTAH

12. MAIDEN NAME OF MOTHER: Ann Smith.

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Agnes Busenbark

(Address) Swan Lake, Idaho

15. Filed 1/31 1929

[signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) - 30 (Day) - 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 6 30 P.M.

The CAUSE OF DEATH* was as follows: Found dead outside and by R.R. track. Probably Sudden Heart Failure

Myocarditis (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ?

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Hartvigsen M. D.

1-31-1929 (Address) Downey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Beaver Dam Utah

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Arthur W. Hall

ADDRESS: Pocatello

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 11 1929

Form V. S. No. 5. 10M. 6-26

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5-3
Primary Registration District No.
File No. 64859
Registered No. 117

1. PLACE OF DEATH
County of Bear Lake
City of Bloomington (No. , Patterson St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lyman ~~Edward~~ Painter

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April 29 (Month) (Day) 1927 (Year)

7. AGE: 1 yrs. 9 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Edward T. Painter

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Dorothy Ann Patterson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E J Painter
(Address) Bloomington Ida.

15. Filed 2-15-1929 Mrs J S Skinner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1929 to Feb 12 1929 that I last saw h~~im~~ alive on Feb 7 1929 and that death occurred on the date stated above, at 2.10 P.M.

The CAUSE OF DEATH* was as follows:
Bronchitis, Acute
(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C O Magee M. D.
2/12 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bloomington Idaho — DATE OF BURIAL: 2-14-1929

20. UNDERTAKER: John Hudson — ADDRESS: Bloomington Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 53
County of Bear Lake Primary Registration District No.
City of Paris (No., St.)
File No. 64860
Registered No. 116
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Frank W. Lewis
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 7 (Day) 1867 (Year)

7. AGE: 62 yrs. 9 mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) Coal Merchant

9. BIRTHPLACE (State or Country) Bear Lake Co. Idaho

10. NAME OF FATHER Joseph Lewis

11. BIRTHPLACE OF FATHER (State or Country) Somersetshire England

12. MAIDEN NAME OF MOTHER Elizabeth King

13. BIRTHPLACE OF MOTHER (State or Country) Somersetshire England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Glenn Lewis
(Address) Paris, Idaho.

15.
Filed 2-16 1929 Mrs. J. S. Hammer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1929 to Feb 12 1929 that I last saw him alive on Feb 11 1929 and that death occurred on the date stated above, at 5.15 A.M.

The CAUSE OF DEATH* was as follows:
Paralysis Intestines
..... (Duration) ..... yrs. ..... mos. 8 ds.
Contributory (Secondary) Chronic Constipation
..... (Duration) 20 yrs. ..... mos. ..... ds.
(Signed) C O Moore M. D.
2/12 1929 (Address) Paris Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris Idaho
DATE OF BURIAL: 2-16 1929
20. UNDERTAKER: Edwin T. Shepherd
ADDRESS: Paris Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 64861
Registered No. 2

1. PLACE OF DEATH.
County of Bear Lake
City of St Charles
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 55
Primary Registration District No. 2134
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Welford C. Floyd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug 7th (Month) ..... (Day) 1889 (Year)

7. AGE: 39 yrs. 6 mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): St Charles Bear Lake Co Idaho

10. NAME OF FATHER: Leonard Floyd

11. BIRTHPLACE OF FATHER (State or Country): Georgetown Essex Co Massachusetts

12. MAIDEN NAME OF MOTHER: Emma Foster

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15.
Filed ..... 191...
Hannah J. Nelson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1926 to Feb 7 1929 that I last saw him alive on Feb 2 1929 and that death occurred on the date stated above, at 7a. M.

The CAUSE OF DEATH* was as follows:
Carcinoma, Liver, Hypertrophic
.....
.....
..... (Duration) 4 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) CO Moore M. D.
Feb 7 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M, 6-20-11. V

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 64862
Registered No. 1

1. PLACE OF DEATH.
County of Bear Lake
City of St. Charles
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 55
Primary Registration District No. 2134
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Shelly Edward Cleveland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1847 (Year)

7. AGE: 82 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) Carpenter

9. BIRTHPLACE (State or Country) new york

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adelia Cleveland
(Address) .....

15.
Filed ..... 191...
Hannah J. Nelson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1929 to Jan 31 1929 that I last saw h alive on Jan 31 1929 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Ca, liver - Secondary
(Cancer)

..... (Duration) ..... yrs. 10 mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C O Moore M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... 191...
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

Public Health Adviser
Food and Drug Inspection
Bacteriological Laboratory
Chemical Laboratory
Sanitary Engineer
Bureau of Child Hygiene
Vital Statistics

DAVID BURRELL, Commissioner

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
Lava Hot Springs, Lava
Idaho Soldiers' Home, Boise
Northern Idaho Sanitarium, Orofino
State School & Colony, Nampa

H. C. BALDRIDGE, Governor

March 19, 1929.

Mrs. Hannah J. Nelson,

St. Charles, Idaho. Re: 64862

Dear Mrs. Nelson:

In order to complete the death certificate of SHELLY EDWARD CLEVELAND who died at St. Charles on January 31, 1929, will you kindly advise whether he was

single, married, widowed or divorced.

An addressed stamped envelope is enclosed for your convenience in returning this letter with the desired information.

Thanking you in advance for a prompt reply, I am,

Respectfully yours,

C. K. Macey

C. K. Macey,
State Registrar.

Shelley Edward Cleveland was married

Hannah J. Nelson
A. N.

FORM V. S. No. RECEIVED MAR 6 1929

CERTIFICATE OF DEATH. 64863

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Benewah
City of 6 miles west of Tensed, Idaho.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 31
Primary Registration District No.
(No. ....., ... St.)

File No. 7
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME ~~Samuel~~ Samuel Baxter.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Dec. 9th. (Month) 1871 (Day) (Year)

7. AGE 57 Yrs. 1 Mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER Daniel Baxter

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Mary Jane Gourley

13. BIRTHPLACE OF MOTHER (State or Country) Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George Baxter.
(Address) Plummer Idaho R.F.D.

15. Filed Febr. 8 1929 John Post Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 5th. (Month) 1929 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 25, 29 191..., to Feb. 5th 191..., that I last saw him alive on Feb. 5th 29 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Uraemia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Flu & Endocarditis

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) C B Clinger M. D.
Feb 6 1929 (Address) Tekoa Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Tekoa Wash. DATE OF BURIAL: 2-11 1929

20. UNDERTAKER: C. L. Schulund ADDRESS: Tekoa Wash.

SYMS - YORK CO., PTRS. & BDRS. 24654

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 13 1929

PLACE OF DEATH

County of Benewah

City of St Maries

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64864

Registration District No. 32

Primary Registration District No. 2049

Local Registrar's No. 1

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna H Tompkins

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 4/10/81

7. AGE Years 47 Months 9 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Syracuse N.Y.

PARENTS

10. NAME OF FATHER John Howard

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Syracuse

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) not known

14. Informant C H Tompkins
(Address) St Maries Ida

15. Filed Jan 19, 1929 O Meroyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6, 1929, to Jan 17, 1929 that I last saw her alive on Jan 17, 1929 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, H.B.P.

Chr. Nephritis (duration) 5 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D Cornwall, M. D.

1/18, 1929 (Address) St Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Woodlawn

Date of Burial Jan. 19 1929

20. Undertaker Mitchell & Meroyer

Address St Maries Ida

RECEIVED FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64865

PLACE OF DEATH
County of Bannock
City of St Maries
Registration District No. 3
Primary Registration District No. 2049
Local Registrar's No. 2
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Amelia Jerusha Clint

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 1842

7. AGE	Years	Months	Days	If LESS than 1 day,
	87.			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Simsbury Conn.

PARENTS

10. NAME OF FATHER Mack

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales England

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) not known

14. Informant John Clint
(Address) St Maries Idaho

15. Filed Jan 23, 1929 O Meneger Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1928, to Jan 23, 1929
that I last saw her alive on Jan 23, 1929
and that death occurred, on the date stated above, at 6:00 P m.
The CAUSE OF DEATH* was as follows:
No particular disease
gradually became weaker
weaker

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G H Cook M. D.
1-4, 1929 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Woodlawn	Jan 27 1929
20. Undertaker	Address
Mitchell & Meneger	St Maries Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64866

PLACE OF DEATH
County of Bennah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

2. FULL NAME Jack Reeves

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Sept. 15 - 1847

7. AGE: Years 81, Months 4, Days 15. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: labour
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS
10. NAME OF FATHER: not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): not known
12. MAIDEN NAME OF MOTHER: not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): not known

14. Informant: C. Mulder
(Address): St Maries Ida

15. Filed Feb 2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH (B)

16. DATE OF DEATH: Jan (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/20, 1927, to 1/30, 1929
that I last saw him alive on 1/30, 1929
and that death occurred, on the date stated above, at 6:30 P m.
The CAUSE OF DEATH* was as follows:
Myocarditis
..... (duration) 2 or 3 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Prostatic Hypertrophy
Nephritis (duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) [signature], M. D.
2/4, 1929 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Woodlawn — Date of Burial: Feb 2 1929

20. Undertaker: Mitchell & Merager — Address: St Maries Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Public Health Adviser
Food and Drug Inspection
Bacteriological Laboratory
Chemical Laboratory
Sanitary Engineer
Bureau of Child Hygiene
Vital Statistics

DAVID BURRELL, Commissioner

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
Lava Hot Springs, Lava
Idaho Soldiers' Home, Boise
Northern Idaho Sanitarium, Orofino
State School & Colony, Nampa

H. C. BALDRIDGE, Governor

March 19, 1929.

Mr. O. G. Merager,

St. Maries, Idaho. Re: 64866

Dear Mr. Merager:

In order to complete the death certificate of JACK REEVES who died January 30, 1929, will you kindly advise whether he was

SINGLE, MARRIED, WIDOWED or DIVORCED.

We enclose herewith an addressed stamped envelope for your convenience in returning this letter with the desired information.

Respectfully yours,

C. K. Macey

C. K. Macey,
State Registrar.

In answer to the above will say Jack Reeves was a single man:- You will pardon me for not seeing that this information was not furnished.

O G Merager
Loc Reg

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 64867

PLACE OF DEATH
County of Bingham
City of Springfield

CERTIFICATE OF DEATH
Registration District No. 116
Primary Registration District No. 2195
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 21

2. FULL NAME Barbara Shelman

(a) Residence. No. ..... St. Springfield Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day and year) X Oct 26, 1925

7 AGE: Years 3 | Months 4 | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) X Santa Cruz Calif

PARENTS
10 NAME OF FATHER Lane Shelman
11 BIRTHPLACE OF FATHER (city or town) (State or country) X Asotin Wash
12 MAIDEN NAME OF MOTHER X Josephine Kerner
13 BIRTHPLACE OF MOTHER (city or town) (State or country) X Blackfoot Ida

14 Informant X Lane Shelman
(Address) Springfield Ida

15 Filed Feb 28, 1929 McMarkinnon
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb (Month) 27 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1928, to Feb 27, 1929
that I last saw her alive on Feb 25, 1929
and that death occurred, on the date stated above, at 8 A m.
The CAUSE OF DEATH* was as follows:
Epidemic cerebro-spinal meningitis
..... (duration) ..... yrs. ..... mos. 65 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No —
What test confirmed diagnosis? Laboratory, Spinal fluid
(Signed) M. C. McKinnon, M. D.
2-27, 1929 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Springfield Ida
Date of Burial: X Feb. 28 1929

20. Undertaker: X none
Address

FORM V. S. No. 5-25 M. 1-19. RECEIVED MAR 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Shelley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ..... , ... St.)

File No. 64870

Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Doris Murphey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: Mch. (Month) 25 (Day) 1925 (Year)

7. AGE: 3 Yrs. 10 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Firth Idaho

10. NAME OF FATHER: Wm Murphey

11. BIRTHPLACE OF FATHER (State or Country): Morgan City Utah

12. MAIDEN NAME OF MOTHER: Jenoretta Owdson

13. BIRTHPLACE OF MOTHER (State or Country): Lehi Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Murphey

(Address) Firth Idaho

15. Filed Feb 4 1929 Mrs Walter E Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8" 1929, to ~~Jan 31~~ Feb 2" 1929, that I last saw her alive on Jan 31" 1929, and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

Feb 4" 29 (Address) Shelley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Firth Cemetery

DATE OF BURIAL: Feb 3rd 1929

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64871

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 29

2. FULL NAME JAMES LLOYD

(a) Residence. No. ..... St. BLACKFOOT, IDAHO
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): SINGLE

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb.10, 1857

7. AGE: 72 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stage driver
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ---
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ---

14. Informant: Fred Hayes
(Address) Blackfoot Idaho Att.

15. Filed Feb. 4, 1929 Wm Calvin E Fitzene Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 3rd, 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct.18, 1928, 19 to Feb 3rd 1929, 19
that I last saw him alive on Feb.2nd, 1929, 19
and that death occurred, on the date stated above, at 2:45 A m.
The CAUSE OF DEATH* was as follows:

CEREBRAL HEMORRHAGE

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
Feb. 4th, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Asylum Cem. | Date of Burial 19

20. Undertaker: J. A. Bailey | Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1929

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. ..... St.)

File No. 64872
Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Clark Holloway

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED, ~~Married~~ Widowed (Write the word.)

6. DATE OF BIRTH. August (Month) 16 (Day) 1849 (Year)

7. AGE 79 Yrs. 5 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farming
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Masouric

10. NAME OF FATHER Joab. Holloway

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thos. Bible
(Address) Blackfoot, Ida

15. Filed ~~Jan~~ Feb 5 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) - 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3rd 1928, to Feb 4 1929, that I last saw him alive on Feb 4 1929, and that death occured on the date stated above, at 8 p. M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

..... (Duration) ..... Yrs. 6 mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. O. Humphrey M. D.
2-5-1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Cambridge Nebr.
DATE OF BURIAL ..... 191....

20. UNDERTAKER E. F. Peck
ADDRESS Blackfoot Ida

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64873

PLACE OF DEATH
County of Bingham
City of Blackfoot.
Registration District No. 121
Primary Registration District No. 2-94,
Local Registrar's No. 31
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myrtle Parker McKnight

(a) Residence. No. Moreland, Ida. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harrison McKnight

6. DATE OF BIRTH (month, day and year) May. 10, 1891.

7. AGE	Years	Months	Days	If LESS than 1 day,
	37	8	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Joseph, Utah.
(State or country)

PARENTS

10. NAME OF FATHER Jos. Wm. Parker.
11. BIRTHPLACE OF FATHER (city or town) Utah.
(State or Country)
12. MAIDEN NAME OF MOTHER Margarete Neil.
13. BIRTHPLACE OF MOTHER (city or town) Kansas
(State or Country)

14. Informant Harrison McKnight
(Address) Moreland, Ida.

15. Filed 3/7, 1929 W. McAdoles Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb, 5. 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
2-5, 1929, to , 19
that I last saw her alive on 2-5, 1929
and that death occurred, on the date stated above, at 9 A. m.
The CAUSE OF DEATH* was as follows:
Mitral regurgitation
(duration) 2 yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of X
Was there an autopsy? no
What test confirmed diagnosis? Clinical symptoms
(Signed) C. O. Harrop M. D.
2-6, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moreland, Idaho.	2-8- 1929

20. Undertaker	Address
Modern Mortuary,	Blackfoot.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64874

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 32

2. FULL NAME JENNIE BELTZ

(a) Residence. No. ..... St. HAGERMAN, IDAHO
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 80 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: HOUSEWIFE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: John McCune
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Don't know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Grace O Clippinger R Nurse
(Address) Blackfoot, Idaho

15. Filed Mr 8, 1929 Mrs Walter E Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 6th, 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1928, 19 to Feb. 6th, 1929, 19
that I last saw her alive on Feb 5th, 1929, 19
and that death occurred, on the date stated above, at 1:30 A m.
The CAUSE OF DEATH* was as follows:

PARALYSIS OF INSANE

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Old Age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
Feb 6th, 1929 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hagerman Ida
Date of Burial: 19

20. Undertaker: E J Park
Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64875

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 33

2. FULL NAME Francis Walters

(a) Residence. No. Blackfoot R F D 2 St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 13 1889

7. AGE: Years 39, Months 1, Days 23. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): West Jordan Utah

PARENTS

10. NAME OF FATHER: Chas. Stedman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Wardel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: C E Walters
(Address) Blackfoot R 2

15. Filed Feb 7, 1929 Mrs Coates E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3, 1929, to Feb 6, 1929
that I last saw her alive on Feb 5th, 1929
and that death occurred, on the date stated above, at 2 A.M. m.
The CAUSE OF DEATH* was as follows: Nephritis + decompensatory heart
..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Chorea
Severe attacks through out life (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? place of death
Did an operation precede death? no Date of .....
Was there an autopsy? no physical examination
What test confirmed diagnosis? Gen of Kidneys - Cardiac findings
(Signed) W. Eagan M. D.
Feb 7, 1929 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverside Thomas
Date of Burial: Feb 8 1929

20. Undertaker: E J Fink
Address: Blackfoot

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS.

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64876

PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2121
Local Registrar's No. 34
(No. O.S.L. Ry Passenger Train)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Francis Jones
(a) Residence. No. St. Butte. Mont.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Colored
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Jan-18-1866 ~~1875~~
7. AGE: Years 63 ~~54~~ Months Days 19 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Mrs. Lacosse
9. BIRTHPLACE (city or town) (State or country): Mo.

PARENTS
10. NAME OF FATHER: Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Mary Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): La

14. Informant: Catherine Douglas
(Address) Lewiston Ida
15. Filed Feb 9, 1929 W. McWalters Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 6th. 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 7:40 A. m.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of X
Was there an autopsy? No
What test confirmed diagnosis? Symptoms & Witnesses
(Signed) F. W. McWalters M. D.
Feb 6 1929 (Address) Blackfoot Ida
Ray McClellan - Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Lewiston Idaho	
20. Undertaker	Address
Modern Mortuary	Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64877

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 35

(No. 406 N. Stout St.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Wesley Kirkpatrick

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) March 14, 1918

7. AGE 10 Years | Months 10 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Blackfoot Idaho

PARENTS

10. NAME OF FATHER Charles Gordon Kirkpatrick

11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia

12. MAIDEN NAME OF MOTHER Mollie Mae Miller

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant Charles Gordon Kirkpatrick
(Address) Blackfoot — Idaho

15. Filed Feb. 9, 1929 Mrs Walter E Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1929, to Feb 8, 1929 that I last saw him alive on Feb 8, 1929 and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) — yrs. — mos. 2 hours

CONTRIBUTORY (Secondary) Spasmodic Croup

(duration) — yrs. — mos. 2 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W A Beck, M. D.

2/9, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Gem City Cemetery | Date of Burial: 2-11 1929

20. Undertaker: E J Funk | Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64878

PLACE OF DEATH

County of Bingham

City of Basalt

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 36

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Franklin Wallace Farnsworth

(a) Residence. No. Balalt, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie Rebecca Andrason

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 73 | Months 7 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired farmer.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Pleasant Grove, Utah

PARENTS

10. NAME OF FATHER: Stephen Farnsworth

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Eliza Lewis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. F.W. Farnsworth
(Address) Basalt, Idaho

15. Filed Feb 19, 1929 Mrs Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-15, 1928, to 2-15, 1929

that I last saw him alive on 2-13, 1929

and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows: Pernicious Anemia

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Edwin Cutler, M. D.

2-19, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rose Hill (Idaho Falls) | Date of Burial: Feb. 19 1929

20. Undertaker: Jack A. Wood | Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64879

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT
Registration District No. 224
Primary Registration District No. 2194
Local Registrar's No. 37
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME HARMON KENEIPP

(a) Residence. No. ..... St. FILER IDAHO
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Molly Keneipp

6. DATE OF BIRTH (month, day and year) Jan. 2nd, 1885

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	1	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lawrence County, Ill

PARENTS

10. NAME OF FATHER Shadrock Kaneipp
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lawrence County, Ill
12. MAIDEN NAME OF MOTHER Lucinda Tally,
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn

14. Informant John Grobsty Att.
(Address) Blackfoot, Idaho.

15. Filed Feb 21, 1929 W. Walter E. Foote
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH FEBRUARY 20th-1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 14th 28, 19, to Feb 20th 1929, 19
that I last saw him alive on Feb. 19th, 1929, 19
and that death occurred, on the date stated above, at 7:50A m.
The CAUSE OF DEATH* was as follows:

SYPHILIS

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Last known
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo. Williams M. D.
Feb 20th, 19 29 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Twin Falls Idaho	
20. Undertaker E. J. Funk	Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64880

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 38
(No. SOUTHERN IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME H. L. DANILSON

(a) Residence. No. ..... St. POCATELLO IDAHO
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE
4. COLOR OR RACE WHITE
5. Single, Married, Widowed, or Divorced (write the word) DIVROCED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 31 Years | Months 10 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ---
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Park City, Utah

PARENTS
10. NAME OF FATHER J. T. Danilson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ---
12. MAIDEN NAME OF MOTHER Mary E Gray
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ---

14. Informant John Grobstig Att.
(Address) Blackfoot, Idaho.

15. Filed Feb. 22, 1929 Mrs Walter E Daniel Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH FEBRUARY 21st 1929 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31st, 1928, to Feb 21 1929, 19..
that I last saw him alive on Feb 21st 1929, 19..
and that death occurred, on the date stated above, at 8:30 A m.
The CAUSE OF DEATH* was as follows:

SYPHILIS

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Dont know
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) G. E. Williams M. D.
Feb 21st, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal G. C. Cemetery | Date of Burial 2-21 1929

20. Undertaker E. J. Bl Peck | Address Blackfoot Ida

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64881

PLACE OF DEATH
County of Bingham
City of Blackfoot #4

Registration District No. 121
Primary Registration District No. 2194

Local Registrar's No. 39

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Barbara Deniece Bowman

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 21, 1929

7. AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.: 11

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Blackfoot, Idaho

PARENTS

10. NAME OF FATHER: Bertram M. Bowman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Verna Barns
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Bertha E. Bowman
(Address) Blackfoot, Idaho

15. Filed Feb 22, 1929 Walter E. Eaton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1929 to Feb 21, 1929 that I last saw h[illegible] alive on Feb 21, 1929 and that death occurred, on the date stated above, at 8:00 P m.

The CAUSE OF DEATH* was as follows:

Patent foramen Ovale

(duration) yrs. mos. 11 Hrs

CONTRIBUTORY (Secondary) Premature birth

(duration) yrs. 8th mos. mo ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W W Beck, M. D.
2/27/1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Thomas Riverside — Date of Burial 19

20. Undertaker: E J Funk — Address: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64882

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
Local Registrar's No. 40

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marguerite Elizabeth Fanslow

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Nov 24 - 1898

7. AGE: Years 30 Months 3 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Marion Ill.

PARENTS

10. NAME OF FATHER: John Henry Fisher
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Mary Matilda Walley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: H. A. Fanslow
(Address) State Hospital Blackfoot

15. Filed Feb. 25, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1929, to Feb 24, 1929
that I last saw her alive on Feb. 24, 1929
and that death occurred, on the date stated above, at 11 A. m.
The CAUSE OF DEATH* was as follows:
Bright disease
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) F. W. Mitchell, M. D.
Feb. 25, 1929 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Marion Ill. Date of Burial 19

20. ~~Undertaker~~ E. F. Funk Address Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64883

PLACE OF DEATH
County of Bingham
City of Blackfoot, Ida
Registration District No. 121
Primary Registration District No. 1007
Local Registrar's No. 41
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wm A. Clarke

(a) Residence. No. 360 North University St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Lydia B. Clarke

6. DATE OF BIRTH (month, day and year) November 22. 1870

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	3	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Zeland

PARENTS

10. NAME OF FATHER Gus M. Clark
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Louise M. Holden
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New Zeland

14. Informant [illegible]
(Address) [illegible]

15. Filed Mar 27, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 25. 1929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at 5.30 P. m.
The CAUSE OF DEATH* was as follows:
Gunshot wound in abdomen,

Accidental.
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? No Date of ...
Was there an autopsy? No
What test confirmed diagnosis? ...
(Signed) Ray McClellan, M.D.
Feb. 26. 19 29 (Address) County Coroner Blackfoot. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Grove City Cemetery	
20. Undertaker	**Address**
E. I. Peck	Blackfoot

Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64884

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 42

2. FULL NAME Ronald G. Keller
(a) Residence. No. Shelley St. Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months 4 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley Idaho

PARENTS
10. NAME OF FATHER Gornard Keller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Smith & Creek Idaho
12. MAIDEN NAME OF MOTHER Connie Alex
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Shelley Idaho

14. Informant Gornard Keller
(Address) Shelley Idaho

15. Filed Feb 28, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1929, to Feb 25, 1929
that I last saw him alive on Feb. 25, 1929
and that death occurred, on the date stated above, at 2:45 a. m.
The CAUSE OF DEATH* was as follows:
Pericarditis
(duration) ..... yrs. ..... mos. 2 ds.
Had some Respiratory involvement
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory test
(Signed) F. E. Keller, M. D.
Feb. 26, 1929 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley, Idaho. Date of Burial Feb 27 1929

20. Undertaker Jack A. Wood Address Ida. Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1929

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64885

Registration District No. 121

Primary Registration District No. 3194

Local Registrar's No. 43

(No. SOUTH IDAHO INSANE ASYLUM)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ELIZABETH PHILLIPS

(a) Residence. No. ..... St. NEWPLYMOUTH-Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE

4. COLOR OR RACE: WHITE

5. Single, Married, Widowed, or Divorced (write the word): WIDOW

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About 89 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: RETIRED

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Grace A. Clippinger Nurse

(Address) Blackfoot, Idaho.

15. Filed March 1, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 28th, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 20th-1929, to Feb. 28th-1929

that I last saw her alive on Feb. 28th-1929

and that death occurred, on the date stated above, at 7:20 P m.

The CAUSE OF DEATH* was as follows:

GENERAL PARALYSIS OF INSANE

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? None

(Signed) G. E. Williams, M. D.

Mar. 1st, 1929 (Address) Blackfoot, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: New Plymouth | Date of Burial: 3-3 1929

20. Undertaker: [illegible] | Address: Blackfoot 29 Ida

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64887

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 3155

Local Registrar's No.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Captain Francis Parnell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 14 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed or divorced
HUSBAND of Mary Parnell
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Dgden
(State or country) Ill

PARENTS

10. NAME OF FATHER Joseph Parnell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Elizabeth Drake
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant C. A. Parnell
(Address) Sandpoint, Idaho.

15. Filed 2-7- 1929 Floyd G. Wendle, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 4th. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan- 24, 1929, to Feb. 4 1929
that I last saw him alive on Feb- 3 TH 1929
and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation

(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Arterio-sclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Montana
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Floyd G. Wendle. M. D.
Feb. 7th. 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harlem. Montana.	Feb. 8th 1929
20. Undertaker Moon Mortuary	Address Sandpoint, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64888

RECEIVED

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Donald Balison

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 2-11-29

7. AGE Years: About 2 hours | Months | Days | If LESS than 1 day, 2 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kootenai Ida

PARENTS

10. NAME OF FATHER: Elwood Balison
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Montana
12. MAIDEN NAME OF MOTHER: Nellie Emery
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): [illegible]

14. Informant: Elwood Emery
(Address) Kootenai, Ida

15. Filed 2-13, 1929 Floyd G. Wendle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-1, 1929, to , 19
that I last saw him alive on 2-11, 1929
and that death occurred, on the date stated above, at 2 a.m.
The CAUSE OF DEATH* was as follows:
Failure of closure of [illegible] of heart and poor nutrition
2 hours (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Illness of mother
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) C E [illegible], M. D.
2-13, 1929 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Boyer Home Pind | Date of Burial: 2-14 1929

20. Undertaker: Elwood Balison Father | Address: Kootenai Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1929

PLACE OF DEATH

County of Bonner

City of Algoma

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78

Primary Registration District No. 2155

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64889

Local Registrar's No. .....

2. FULL NAME Effie Elizabeth Davis

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Dillard Davis

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10. NAME OF FATHER J. M. Moore

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Jennie Melton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Dillard Davis

(Address) Algoma Idaho

15. Filed Feb. 14, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11, 1929 to ....., 19.....

that I last saw her alive on Feb 11, 1929

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Abortion two days before
Feb 11 Embolism of Brain
Coma 2 hours

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) L E Alcorn, M. D.

2-13, 1929 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Westmond Cemetery	Feb. 14, 1929
20. Undertaker	**Address**
Moon Mortuary	Sandpoint, Ida

RECEIVED MAR 8

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64890

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Norma Henriette Leger

(a) Residence. No. St. Clarkfork Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married-

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Edgar Noel Leger

6. DATE OF BIRTH (month, day and year) Nov 26 1896

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32	2	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Ida-

PARENTS

10. NAME OF FATHER David Y. Hale
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn-
12. MAIDEN NAME OF MOTHER Eda L. Herty
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Fremont Ohio.

14. Informant Edgar N Leger-
(Address) Clarkfork Ida-

15. Filed Feb. 15, 1929 Vida Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1929, to Feb. 12, 1929
that I last saw her alive on Feb. 12, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Septicemia following
Pneumonia (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
Feb. 15, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery.	Feb 15, 1929
20. Undertaker	**Address**
Moon Mortuary	Sandpoint Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64891

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.

PLACE OF DEATH
County of Bonner
City of Kootenai
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Simeon Blair

(a) Residence. No. St. Kootenai, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Mary Blair

6. DATE OF BIRTH (month, day and year) June 10, 1858

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70	8	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mill worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Quebec, Canada

PARENTS

10. NAME OF FATHER Simeon Blair
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Quebec Canada
12. MAIDEN NAME OF MOTHER Marie Dichlais
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Quebec Canada

14. Informant Mrs. A. E. Cherry
(Address) Sandpoint, Idaho

15. Filed Feb 18, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1924, to Feb 16, 1929
that I last saw h~~im~~ alive on Jan 31, 1929
and that death occurred, on the date stated above, at 7 30 P m.
The CAUSE OF DEATH* was as follows:
Diabetes.
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) C F Sayre, M. D.
Feb. 18, 1929 (Address) Sandpoint Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Feb. 19 1929
20. Undertaker	Address
Moon Mortuary	Sandpoint Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64892

RECEIVED MAR 6 1929

PLACE OF DEATH

County of Bonner

City of Sandpoint (rural)

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No. Pack River School District)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gladys Pearl Lortz

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 26 1912

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
16	8	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nebraska

PARENTS

10. NAME OF FATHER: Alvin E Lortz

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mable Mattison

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Neb

14. Informant: A E Lortz

(Address) Pack River

15. Filed Feb. 18, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3, 1929, to Feb 17, 1929

that I last saw her alive on Feb 17, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Difficult Labor Peritonitis following.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ignorance of patient of condition

(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C E Alcorn, M. D.

2-18, 1929 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery

Date of Burial: Feb 21 1929

20. Undertaker: Turnbull Co

Address: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64894

PLACE OF DEATH

County of Bonner
City of Sandpoint, Idaho
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Rennis

(a) Residence. No. St. Clarksfork, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 67			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Prospector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant L. G. Moon
(Address) Sandpoint Idaho.

15. Filed Feb. 23, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 9, 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 2, 19 29 to Feb. 9, 1929 19
that I last saw him alive on Feb. 8, 1929, 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Floyd G. Wendle, M. D.
Feb. 9, 19 29 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	2/23, 1929
20. Undertaker L. G. Moon	Address Sandpoint Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64895

PLACE OF DEATH

County of Bonner Registration District No. 78

City of Sandpoint Ida Primary Registration District No. 215

Local Registrar's No.

(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ray Simpson

(a) Residence. No. St. Cocolalla Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 4, 1902

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	5	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Common Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant George Simpson
(Address) 911-N-94th St Kansas City Kan.

15. Filed Feb 25, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6, 1929 to Jan 15, 1929
that I last saw him alive on Jan 15, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

I (a) Uremia
Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Floyd A. Wardle, M. D.
Feb 25, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	2/25, 1929

20. Undertaker L. G. Mason Address Sandpoint Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 7 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64896

PLACE OF DEATH
County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
(No.)
Local Registrar's No. 4
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Theresia Schwartz

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ignatz Schwartz

6 DATE OF BIRTH (month, day and year) Oct. 22, 1846

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) X Zvittau Austria Hungary

PARENTS
10 NAME OF FATHER John Schmidt
11 BIRTHPLACE OF FATHER (city or town) (State or country) Zvittau Austria Hungary
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs John Specht
(Address) Priest River, Idaho

15 Filed Feb 8, 1929 R. E. Wiesna Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
February (Month) 6, (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1929, to Feb 6, 1929, that I last saw her alive on Feb 6, 1929, and that death occurred, on the date stated above, at 5:50 P. m.

The CAUSE OF DEATH* was as follows:
Cardiac renal vascular disease
(duration) about yrs. mos. ds.
CONTRIBUTORY (Secondary) old age
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs

(Signed) P A Lowes, M. D.
Feb 7, 1929 (Address) Priest River, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Woodmen Cemetery	Feb. 9, 1929
20. Undertaker	Address
Moon Mortuary	Priest River

RECEIVED FEB 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 64897

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonneville Registration District No. 73

City of Idaho Falls Primary Registration District No. 2100

(No. L. D. S. Hosp.) Local Registrar's No. 12

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Sarah Elizabeth Selck.

(a) Residence. No. Menan Idaho. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Married.

5a If married, widowed, or divorced ~~HUSBAND~~ of X
(or) WIFE of W. W. Selck.Jr.

6 DATE OF BIRTH (month, day and year) Sept. 2, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	53	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10 NAME OF FATHER Orrin M. Myler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Utah.

12 MAIDEN NAME OF MOTHER Elizabeth Jane Stokes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Christine Selck

(Address) Menan, Idaho.

15 Filed Jan 31, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 28. 1929.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1929, to Jan. 28, 1929, that I last saw her alive on Jan. 28 1929, and that death occurred, on the date stated above, at 5:30A m.

The CAUSE OF DEATH* was as follows:

Infection following Amputation of Femur.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Thrombo-phlebitis of Leg Myocardial degeneration.

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Menan

Did an operation precede death? yes Date of Jan. 25 29.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. A. Nist M. D.

Jan. 29, 1929 (Address) Rigby, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Lewisville, Idaho.	1/31/29 19

20. Undertaker A B Eckersell Address Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 22 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64898

PLACE OF DEATH

County of Bonneville.

City of Idaho Falls.

Registration District No. 73

Primary Registration District No. 2150

Local Registrar's No. 1 V —

(No. Ch-D. S. Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Clay Hollister.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Mabel Hollister.

6. DATE OF BIRTH (month, day and year): 1866

7. AGE: Years 63 | Months 2 | Days 27. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Physician & Surgeon.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Red Bluff Cal.

PARENTS

10. NAME OF FATHER: Thomas J. Hollister.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wilkesbarre Penn.

12. MAIDEN NAME OF MOTHER: Elizabeth Pyle.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Long Branch N. J.

14. Informant: Mrs Mabel Hollister.
(Address): Idaho Falls. Ida.

15. Filed Jan 29, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11 p.m. Jan. 17, 1929, to Jan. 27, 1929 that I last saw him alive on Jan. 26, 1929 and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Peritonitis, Gangrenous, Appendicitis, Thrombophlebitis (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes. Date of Jan. 18, 1929

Was there an autopsy? No.

What test confirmed diagnosis? Operation & observation

(Signed) Harry L. Willson, M. D.

1/29, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: Jan. 30. 1929

20. Undertaker: V. F. McHan. | Address: Idaho Falls Idaho.

RECEIVED FEB 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64899

PLACE OF DEATH
County of Bonneville
City of Idaho Falls. Registration District No. 73
Primary Registration District No. 214
(No. L-D-S Hospital.) Local Registrar's No. 14
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wallace Frew.

(a) Residence. No. Idaho Falls - Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male.	white.	married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of mrs alice Fitzpatrick Frew

6. DATE OF BIRTH (month, day and year) Feb. 9 - 1884

7. AGE	Years	Months	Days	If LESS than 1 day,
	44	11	13.	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden Utah.

PARENTS

10. NAME OF FATHER Hyrum. Frew.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Franklin Idaho.
12. MAIDEN NAME OF MOTHER Hanna Everett.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ogden Utah.

14. Informant Hyrum Frew
(Address) Idaho Falls. Idaho

15. Filed 1/23, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January. 22. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to Jan 22, 1929, that I last saw h[illegible] alive on Jan 22, 1929, and that death occurred, on the date stated above, at 4:10 P m.

The CAUSE OF DEATH* was as follows:

Tumor Spinal Cord

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) [illegible], M. D.
Jan, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls.	Jan 25 1929

20. Undertaker	Address
V. F. M Han[illegible]	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64900

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 13
Primary Registration District No. 214-0
Local Registrar's No. 13
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Pearl Jenkins
(a) Residence. No. Idaho Falls Route # 5 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Dave Jenkins
6. DATE OF BIRTH (month, day and year) August 16 1883
7. AGE Years 43 Months 5 Days 4 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Rawlins Wyoming
PARENTS
10. NAME OF FATHER Sam Bedsaulty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Mary Lizzie Boughertty
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas
14. Informant Orin Jenkins
(Address) Idaho Falls Idaho
15. Filed Jan 23, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 20 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 2 P.M. Jan 20th, 1929, to 4.15 P.M., 1929
that I last saw her alive on 1-20-, 1929
and that death occurred, on the date stated above, at 4-15 P m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
There was inequality of pupils.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Ask Dr Jabez West whom I understand wanted another Dr. called.
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Ptosis and extreme dilatation left Pupil
(Signed) G W Pendleton, M. D.
Jan 23, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho Date of Burial Jan 23 1929
20. Undertaker Jack A. Ward Address Idaho Falls

RECEIVED FEB 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64901

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2 1470
Local Registrar's No. 12
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clarabelle Bowman

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Irvin E Bowman

6. DATE OF BIRTH (month, day and year) April 1 1902

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
26	9	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Harry D. Neifert
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Delia Sippels
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant I. E. Bowman
(Address) Ashton Ida

15. Filed Jan 17, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Jan 15, 1929
that I last saw her alive on ....., 19..
and that death occurred, on the date stated above, at 10.45 P. m.
The CAUSE OF DEATH* was as follows:

Embolism
(duration) ..... yrs. ..... mos. 2 hrs

CONTRIBUTORY (Secondary) Operation – Chronic Appendicitis – Multiple Oophoritis
(duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Jan 6/29
Was there an autopsy? Post Spinal puncture
What test confirmed diagnosis? Examination
(Signed) [signature], M. D.
Jan 15, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashton Idaho
Date of Burial: Jan 20 1929

20. Undertaker: V. F. McHan
Address: Idaho Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 22 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Fall

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64902

Registration District No. 73

Primary Registration District No. 21 V 5

(No. L.D.S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

2. FULL NAME Clawson Leavitt

(a) Residence. No. Blackfoot Idaho Route 4 St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Violet Etcher Adams

6. DATE OF BIRTH (month, day and year) June 22, 1904

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
24	6	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER James B. Leavitt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Pemina Rawlins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant N. S. Leavitt

(Address) Blackfoot Idaho #4

15. Filed Jan 10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 9th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1928, to Jan 6, 1929

that I last saw him alive on Jan 6, 1929

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? Moreland Idaho

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. E. Tatris, M. D.

Jan 9, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Moreland Idaho

Date of Burial Jan 1929

20. Undertaker Brown Eldredge

Address Blackfoot Idaho

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64903

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 3
Primary Registration District No. 21-0
Local Registrar's No. 10
(No. Cutler Hotel.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fay Marie McFarland.

(a) Residence. No. 7 Spencer Idaho St. Spencer Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 21-1925

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	7	20	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gooding Idaho

PARENTS

10. NAME OF FATHER Parley P. McFarland.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Weber. Utah.

12. MAIDEN NAME OF MOTHER Estella Howells.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Paradise Utah.

14. Informant P. P. McFarland.
(Address) Spencer Idaho.

15. Filed 1/11, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 10 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1929, to Jan 10, 1929
that I last saw her alive on Jan 10, 1929
and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 7 ds.

CONTRIBUTORY —
(Secondary)

(duration) yrs. mos. ds.

*18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) H. Ray Peters M. D.

Jan 11, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ogden Utah	Jan 12 1929

20. Undertaker V. F. McHan. Address Idaho Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64904

RECEIVED FEB 22 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 21 V 10

Local Registrar's No. 9

(No. L. O. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Norman Orley Quinn

(a) Residence. No. ..... St. Shelley, Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 9 1926

7. AGE Years 3 Months 10 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley, Idaho

PARENTS

10. NAME OF FATHER Orley Quinn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mississippi

12. MAIDEN NAME OF MOTHER Golda Christensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Shelley, Idaho

14. Informant Ody Quinn

(Address) Shelley, Idaho

15. Filed 1/11, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 9 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-9, 1929, to 1-9, 1927

that I last saw him alive on 1-9, 1929

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? microscopic

(Signed) Edwin Cutler, M. D.

1-11, 1929 (Address) Shelley, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Firth, Idaho

Date of Burial Jan 11 1929

20. Undertaker Jack A. Wood

Address Idaho Falls.

RECEIVED FEB 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64905

PLACE OF DEATH
County of Bonneville.
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 8
(No. KNUDSEN)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lela Mildred Knudsen.
(a) Residence. No. 4 Miles So of Idaho Falls.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. — mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec 6. 1922.
7. AGE: Years 6, Months 0, Days 29. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho Falls.

PARENTS
10. NAME OF FATHER Ernest Knudsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway.
12. MAIDEN NAME OF MOTHER Elsie Seyfert
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho Falls.

14. Informant Elsie Seyfert Knudsen
(Address) R.D. 6. Idaho Falls.
15. Filed 1/9, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 5 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, ~~That I attended deceased from~~ ....., 19....., to ....., 19.....
~~that I last saw it [illegible]~~ on ....., 19.....
and that death occurred, on the date stated above, at 3 45 P. m.
The CAUSE OF DEATH* was as follows:
Accidental - Automobile struck by train
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
1/9/29, 19.... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: Jan 9 1929
20. Undertaker: V. F. McHan. Address: ~~V. F. M~~ Idaho Falls.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64906

Local Registrar's No. 7

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2170
(No. 240 S Montpelier)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vain Harrison Priest
VAIN HARRISON PRIEST

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 14 - 1916

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Taylor. Ida

PARENTS

10. NAME OF FATHER Wm E Priest
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Mable J Young
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Wm Newton Gibbs
(Address) 315 N. Water ave.

15. Filed 1/9, 1929 Jas Summerhays Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 9 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1929 to Jan 9, 1929
that I last saw h[illegible] alive on Jan 8, 1929
and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:
Epidemic Cerebro Spinal Meningitis
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Same
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? at Shelley Ida
Did an operation precede death? no Date of
Was there an autopsy? No
What test confirmed diagnosis? Menings-Coccus in spinal fluid
(Signed) H. E. Zeuker, M. D.
Jan 9, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Taylor, Ida — Date of Burial: Jan 1[illegible] 1929
20. Undertaker: Cliff Hayes — Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64907

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21 V-0
Local Registrar's No. 6
(No. I.D.S. Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nathan Ricks
(a) Residence. No. 1st N. 2nd E. Rexburg Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jannette Ricks

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 75, Months 11, Days 13. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS
10. NAME OF FATHER: Joel Ricks
11. BIRTHPLACE OF FATHER (city or town) (State or Country): America
12. MAIDEN NAME OF MOTHER: Elenor Marten
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): America

14. Informant: Ray Ricks
(Address) Salt Lake City Utah

15. Filed Jan 9, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 1 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Crushing injury chest
Automobile accident
..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) —
— (duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) W Ray Hatch M. D.
Jan 4, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rexburg Ida. Date of Burial: 1/3 1929

20. Undertaker: A B Eckersell Address: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 64908

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonneville. Registration District No. 73

City of Idaho Falls, Idaho Primary Registration District No. 214

Local Registrar's No. 1

(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Forest Keith Keele.

(a) Residence. No. L. D. S. Hosp. St. Ririe Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Babe.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) August 21 1927

7 AGE: Years 1 | Months 4 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Babe.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10 NAME OF FATHER Ellis J. Keele.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Utah.

12 MAIDEN NAME OF MOTHER Earthel Clark.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho.

14 Informant Ellis J Keele
(Address) Ririe, Idaho.

15 Filed Jan 9, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 7 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Jan 7, 1929, that I last saw him alive on Jan 7, 1929, and that death occurred, on the date stated above, at 1:50 p. m.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebral Sp. Meningitis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Influenzal pneumonia

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? Riri Idaho

Did an operation precede death? no Date of

Was there an autopsy? Spinal Fluid Tests only

What test confirmed diagnosis? yes see above

(Signed) [signature], M. D.

1/7, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Ririe, Shelton Cem. | Date of Burial: 1/8/29 19

20. Undertaker: A B Eckersell | Address: Rigby.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64909

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21-0
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

2. FULL NAME Masao Harada.
(a) Residence. No. 5 Miles North of Idaho Falls. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: Japanese
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) March 15 1928.
7. AGE: Years 0, Months 7, Days 16, If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) ~~O. Harada~~ Idaho Falls Ida.

PARENTS
10. NAME OF FATHER O. Harada.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan.
12. MAIDEN NAME OF MOTHER S. Tokudara.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Japan.

14. Informant O. Harada.
(Address) Idaho Falls. Ida.

15. Filed 1/2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 1 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 12-30-, 1928, to 1-1-, 1929
that I last saw him alive on ....., 19....
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:
Influenza
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis? T. Hollister
(Signed) ....., M. D.
1/2, 1929 (Address) [signature]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: Jan 2 1929
20. Undertaker: V. F. McHan. Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64910

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 13
Primary Registration District No. 210
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

2. FULL NAME Edward Stevens
(a) Residence. No. ~~Ida~~ Osgood. Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male.
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec. 6-1928
7. AGE Years Months Days 26. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho Falls.

PARENTS
10. NAME OF FATHER John Stevens.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Europe.
12. MAIDEN NAME OF MOTHER Eva. Moore.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Europe.

14. Informant John Stevens.
(Address) Osgood. Idaho

15. Filed 1/2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-31-, 1928, to 1-1-, 1929
that I last saw him alive on ....., 19....
and that death occurred, on the date stated above, at 1 A m.
The CAUSE OF DEATH* was as follows:
Influenza
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis? T. S. Hollister
(Signed) ....., M. D.
1/2, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls — Date of Burial Jan 2 1929
20. Undertaker V. F. McHan. — Address Idaho Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64911

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2147
(No. L.O.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

2. FULL NAME Bervadawn Landon
(a) Residence. No. ..... St. Idaho Falls Route #7
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): April 29, 1928
7. AGE Years: Months 8 Days 3 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Asgood, Idaho

PARENTS
10. NAME OF FATHER: Charles Landon
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Gladys Sessions
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Afton Wyoming

14. Informant: Charles Landon
(Address) Route #7, Idaho Falls
15. Filed 1/1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 1 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia — No medical attendance
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
1/9, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Goshen, Idaho — Date of Burial: Jan 3 1929
20. Undertaker: Jack A. Wood — Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64912

Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 1

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Hale

(a) Residence. No. ____ St. Shelley #1
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 31 1928

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
			1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Idaho

PARENTS

10. NAME OF FATHER Joseph Hale
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Preston, Idaho
12. MAIDEN NAME OF MOTHER Rosella Clark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St Charles Idaho

14. Informant Joseph Hale
(Address) Shelley #1

15. Filed Jan 1, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31, 1928, to Jan 1, 1929,
that I last saw h[illegible] alive on Jan 1, 1929,
and that death occurred, on the date stated above, at 12-30 P m.

The CAUSE OF DEATH* was as follows:
Concussion of Brain
Caused from Instrument
Delivery.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible] M. D.
1-2, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Smithfield Utah	Jan 3 1929

20. Undertaker Jack A. Wood Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64918

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 1
Primary Registration District No. 2006
(No. 1 mile North Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 27

Ross

2. FULL NAME Helen Lucile Clay

(a) Residence. No. 1 mile north Nampa St.
(Usual place of abode)
Length of residence in city or town where death occurred. 18 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 24th 1910

7. AGE	Years	Months	Days	If LESS than 1 day,
	18	8	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Nampa
(State or country) Idaho

PARENTS

10. NAME OF FATHER Clarence Clay

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) West Virginia

12. MAIDEN NAME OF MOTHER Elizabeth Crider

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Minnesota

14. Informant Mrs. Clarence Clay
(Address) Nampa, Idaho

15. Filed 3/5, 1929 Stella Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 28th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1928, to Feb 28, 1929
that I last saw her alive on Feb 28, 1929
and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular insufficiency mitral & Tricuspid
(duration) 17 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs

(Signed) H. P. Cook, M. D.
Feb 28, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn, Nampa	3-3 1929
20. Undertaker	Address
Mrs. Nina M. Talley	Nampa, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAR 7 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 4
(No. ..... St.)

State File No. 64919
Local Registrar's No. 26
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amanda K. Trigg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widowed

6. DATE OF BIRTH: Oct (Month) 9 (Day) 1853 (Year)

7. AGE: 75 Yrs. ..... Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF Father: Enos Tyler

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. K. Gibellan
(Address) R#5 Nampa Idaho

15.
Filed 3-24 1929 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15 1929 to Feb 20 1929
that I last saw h[illegible] alive on Feb 20 1929
and that death occurred on the date stated above, at 2 A. M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Samuel A. Swayne M. D.
19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roberlawn Cem. | DATE OF BURIAL: 3-24 1929

20. UNDERTAKER: Ted K. Harrison | ADDRESS: Nampa Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64920

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 24

2. FULL NAME William P. Small

(a) Residence. No. West of Nampa St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sadie Small

6. DATE OF BIRTH (month, day and year) June 26th 1896

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
32	7	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER George Small
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennessee
12. MAIDEN NAME OF MOTHER Anna Kimberling
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant B. H. Small
(Address) Harper, Oregon

15. Filed 2/26, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 24th 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/22, 1929, to 2/25, 1929,
that I last saw him alive on 2/24, 1929,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Pulmonary embolus.
(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Endocarditis.
(duration) 2 yrs. 0 mos. 0 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? auscultation & percussion
(Signed) Geo. O. L. Kellogg, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Nampa
Date of Burial: 2/26 1929

20. Undertaker: Wm Talley
Address: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 7

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64921

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1107
(No. 323 Maple St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

2. FULL NAME Clara E. Roulet
(a) Residence. No. 323 Maple St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: L. S. Roulet

6. DATE OF BIRTH (month, day and year): June 6th 1874

7. AGE: Years 54, Months 8, Days 14. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Bluffton Ohio

PARENTS

10. NAME OF FATHER: Jacob Burkholder
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Mary Hilty
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Mr. L. S. Roulet
(Address): Nampa, Idaho

15. Filed 2-24, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 20th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ___, 19___, to ___, 19___
that I last saw h___ alive on ___, 19___
and that death occurred, on the date stated above, at 7:10 P. m.
The CAUSE OF DEATH* was as follows:
apoplexy
(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary): Asthma and acute indigestion
(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? This evidence from family history of the case and
Did an operation precede death? Date of
Was there an autopsy? Date of physician called after death
What test confirmed diagnosis?
(Signed) Paul L. Case, M. D.
2-23, 1929 (Address) Corner Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa
Date of Burial: 2-24 1929

20. Undertaker: Mrs. Nina M. Talley
Address: Nampa Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64922

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No.
Primary Registration District No. 2205
(No. 207 Elder St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME ~~Elana~~ Sarah J. Snyder

(a) Residence. No. 4 miles north Nampa St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Amos E. Snyder

6. DATE OF BIRTH (month, day and year) Sept 8 1866

7. AGE	Years	Months	Days	If LESS than 1 day,
	62	5	9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9. BIRTHPLACE (city or town) (State or country) Ohio
10. NAME OF FATHER Samuel Clutter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ver.
12. MAIDEN NAME OF MOTHER Eli Pfeifer.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mr. Paul Snyder
(Address) Nampa Idaho

15. Filed , 19 , Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 17th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1929, to Feb 17, 1929
that I last saw her alive on Feb 17, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH was as follows:
Apoplexy
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) W C Wolter, M. D.
2/18, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	2-20 1929
20. Undertaker	Address
Mrs. Nina M. Talley	Nampa, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64923

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 2006

Local Registrar's No.

(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth Madworth Ward

(a) Residence. No. 5 mi. south of Nampa St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 29th

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
10	9	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Oklahoma

PARENTS

10. NAME OF FATHER: Ralph R. Ward

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Laura Mendenhall

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Nebraska

14. Informant: Mrs. Ralph Ward
(Address) R.F.D. #4 Nampa, Idaho

15. Filed 2-15, 1929 Bertha Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 13th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1929, to Feb 13, 1929
that I last saw her alive on 2-15-, 1929
and that death occurred, on the date stated above, at 12:45 P.m.

The CAUSE OF DEATH* was as follows:
Edema lungs

(duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary): Flu pneumonia
Myocarditis (duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H P Belknap, M. D.

2/13, 1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlaw - Nampa
Date of Burial: 2/15 1929

20. Undertaker: Nina M. Talley
Address: Nampa

RECEIVED MAR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64924

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 17

PLACE OF DEATH
County of Canyon
City of Caldwell

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gloria June Howard

(a) Residence. No. 601 Kimball Ave. Caldwell Ida.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Girl	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3	9	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho Ada County USA.

PARENTS

10. NAME OF FATHER Joan a Howard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Edgar Neb.
12. MAIDEN NAME OF MOTHER Martha Hazel McDougal
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Friend Neb.

14. Informant Joan A. Howard
(Address) 601 Kimball Ave. Caldwell Idaho

15. Filed 3-5- 1929 John L. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 3 1929 to Mar 5 1929
that I last saw her alive on Mar 4 1929
and that death occurred, on the date stated above, at 4.30 a.m.
The CAUSE OF DEATH* was as follows:

Influenza 6 ds.
(duration) yrs. mos.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) W. M. Staley M. D.
3-5- 29 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Boise	Mar. 1929
20. Undertaker	Address
Wm McBratney	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 12 1929

PLACE OF DEATH

County of Canyon

City of Middleton

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64925

Local Registrar's No. 16

2. FULL NAME John David Caldwell

(a) Residence. No. R F D Middleton Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Anna R Clark Caldwell

6. DATE OF BIRTH (month, day and year) July 5 1860

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	7	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Abner Caldwell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Lydia Mankins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas

14. Informant Mrs Anna Caldwell

(Address) R F D Middleton Ida

15. Filed 3-5-, 1929- John S. Meyer- Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 2-29 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1929, to March 2, 1929

that I last saw him alive on March 1st, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Hemmorhag from Stomach

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) (Probable) Carcinoma

..... (duration) ..... yrs. 4 mos. ..... ds.

18. Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptom

(Signed) [signature], M. D.

4/5, 1929 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill

Date of Burial: Mch 5-29 19

20. Undertaker: Paul L. Case

Address: Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64926

PLACE OF DEATH

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 15
(No. Caldwell Sanitarium.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Sophie Obendorf

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 21, 1855

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	5	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Fredrick Viedt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Magdela Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant F. C. Obendorf
(Address) Wilder, Idaho

15. Filed 2-22-, 1929 John S. Mayer. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4, 1929, to Feb 21, 1929
that I last saw h[illegible] alive on Feb 20, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) 3 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? yes Date of Feb 20 29
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) [signature], M. D.
2/22, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Roswell Cemetery	Feb 24-29

20. Undertaker	Address
Paul L. Case	Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64927

PLACE OF DEATH
County of Canyon
City of Greenleaf

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 14

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Catherine Turner

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Oct. 8 1844

7. AGE: 84 Years, Months: 4, Days: 10. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Richmond Virginia

PARENTS

10. NAME OF FATHER: Abner Rinhard
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Sally Pugh
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14. Informant: S. A. Turner
(Address): Greenleaf Ida

15. Filed 2-19-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1928, to Feb 18, 1929
that I last saw her alive on Feb 8, 1929
and that death occurred, on the date stated above, at 7:15 P m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage with paralysis
one (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical symptoms
(Signed) [signature], M. D.
2/19, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Marshall Town, Iowa
Date of Burial: 19

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64928

PLACE OF DEATH
County of Canyon
City of Middleton

Registration District No. 9
Primary Registration District No. 2005
Local Registrar's No. 13

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Murnie M. Hadsall
(a) Residence. No. Middleton St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Perry D Hadsall

6. DATE OF BIRTH (month, day and year) July 23" - 1865

7. AGE: Years 63, Months 6, Days 24. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ashland Nebraska

PARENTS

10. NAME OF FATHER S Thomas Fox
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Malcina Barnhill
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant Perry D Hadsall
(Address) Middleton Idaho

15. Filed 2-19-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1928, to Feb, 1929
that I last saw her alive on Aug, 1928
and that death occurred, on the date stated above, at 9:40 P.m.
The CAUSE OF DEATH was as follows: Pulmonary Tuberculosis
..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Sputa test
(Signed) J. Mosley, M. D.
2-18, 1929 (Address) Caldwell Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Middleton
Date of Burial: Feb. 19 1929

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

9.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64929

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

2. FULL NAME Sue Brazile

(a) Residence. No. 1418 Blaine St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 27" - 1876

7. AGE Years: 52 Months: 2 Days: 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10. NAME OF FATHER: Jacob Hale
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: J. T. Brazile
(Address) 1418 Blaine St. Caldwell Ida

15. Filed 2-16-, 1929 John S. Meyes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1929, to Feb 14, 1929
that I last saw her alive on Feb 8 1929
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis.

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nurities & Heart (duration) 15 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) T. D. Forms M. D.
2/15, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 2:30

19. Place of Burial, Cremation, or Removal: Canyon Hill. Date of Burial: Feb. 17 1929

20. Undertaker: C. V. Peckham Address: Caldwell, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64930

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 11

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lamira Elizabeth Springer
(a) Residence. No. RD# 2 St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Geo A Springer

6. DATE OF BIRTH (month, day and year): April 23 - 1852

7. AGE: Years 76, Months 9, Days 21. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): St. Clair Co. Mich.

PARENTS

10. NAME OF FATHER: James Burtch
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Emila Thorp
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): York State

14. Informant: Geo A Springer
(Address) RR# 2 Caldwell Idaho

15. Filed 2-16-, 1929. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 10, 1929, to February 14, 1929
that I last saw her alive on February 13, 1929
and that death occurred, on the date stated above, at 2:20 P m.
The CAUSE OF DEATH* was as follows:
apoplexy

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary): Two previous

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) C R Whittenberger D.O. M. D.
February 15, 1929 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. DPM

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 2-16 1929

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

RECEIVED MAR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64931

PLACE OF DEATH

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 3005 (1005) Local Registrar's No. 10
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Landauer

(a) Residence. No. 303 Aven St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	white	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 12 - 29.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or 5 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho

PARENTS

10. NAME OF FATHER Robt Laundower
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Elizabeth Ragsdale
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Robert Landauer
(Address) 303 aven Caldwell Idaho.

15. Filed 2-12-, 1929 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12, 1929 to Feb 12, 1929
that I last saw h[illegible] alive on Feb 12, 1929
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows: Dystocia with Spina Bifida.
(duration) yrs. mos. 5 min
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) S R Dreeby M. D.
Feb 12, 1929 (Address) Caldwell, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	2 - 12 " 1929
20. Undertaker C. V. Peckham	Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 61992

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. Caribou Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

2. FULL NAME Myrtle Coy Haderlee
(a) Residence. No. ..... St. Thayne, Wyo.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Clifford Haderlee
6. DATE OF BIRTH (month, day and year) July 20-1903
7. AGE 25 Years Months 6 Days 18 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Thayne Wyoming

PARENTS
10. NAME OF FATHER John A. Coy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Emma Herrick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs John A. Coy
(Address) Thayne Wyo.
15. Filed Feb. 8, 1929 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 7 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 4, 1929, to Feb 7, 1929
that I last saw her alive on Feb 7, 1929
and that death occurred, on the date stated above, at 5 p.m.
The CAUSE OF DEATH* was as follows:
Eclopic Pregnancy
..... (duration) ..... yrs. 3 mos. ..... ds.
CONTRIBUTORY (Secondary) 0
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of 2-4-29
Was there an autopsy? 0
What test confirmed diagnosis? Operation
(Signed) Ellis Kackley M. D.
2-8-, 1929 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Thayne Wyoming Date of Burial Feb. 12 1929
20. Undertaker J. M. McCharen Address Montpelier Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64933

PLACE OF DEATH

County of Caribou

City of Soda Springs

Registration District No. 82

Primary Registration District No. 2159

Local Registrar's No. 3

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William J. Smith

(a) Residence. No. Soda Springs Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Florence Smith

6. DATE OF BIRTH (month, day and year): Dec 13-1869

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	2	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Business man

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Pinebush N.Y.

PARENTS

10. NAME OF FATHER: Ezra Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Dorathy J. Corwin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New York St.

14. Informant: F. L. Smith
(Address) Pontiac Ill.

15. Filed 2-25, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to Feb 23, 1929
that I last saw him alive on Feb 23, 1929
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Nephritis

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary): 0

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? 0 Date of

Was there an autopsy? 0

What test confirmed diagnosis? Ex. Urine

(Signed) Eric Kaahy, M. D.

2-27-, 1929 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Soda Springs Idaho — Date of Burial: 2-25-1929

20. Undertaker: C. L. Whitman — Address: Soda Springs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64934

PLACE OF DEATH
County of Caribou
City of Soda Springs
Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

2. FULL NAME Mary Whitley Allred
(a) Residence. No. Soda Springs Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Fred. H. Allred

6. DATE OF BIRTH (month, day and year) Aug 8th 1895

7. AGE Years 33 Months 5 Days 0 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Thatcher Idaho

PARENTS
10. NAME OF FATHER Frank E. Thirkell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake Utah
12. MAIDEN NAME OF MOTHER Lulu Thatcher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Logan Ut.

14. Informant Fred H Allred
(Address) Soda Springs Ida

15. Filed 2-12, 1929 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6, 1929, to Feb 8, 1929
that I last saw her alive on Feb. 8, 1929
and that death occurred, on the date stated above, at 7:30 P m.
The CAUSE OF DEATH* was as follows:
Paralysis of Bowels
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Chron Appendicitis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 2-1-29
Was there an autopsy? 0
What test confirmed diagnosis? Physical Ex
(Signed) Ellis Kirk Ly, M. D.
2-8-, 1929 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida — Date of Burial 2-12-1929

20. Undertaker E. L. Whiteman — Address Soda Springs Ida

RECEIVED FEB 26 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64935

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. 117
Primary Registration District No. 2196
(No.)
Local Registrar's No. 17

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Forest Littlefield

(a) Residence. No. 164 So Albion St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 13, 1927

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	7	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida

PARENTS

10. NAME OF FATHER Alonzo Littlefield
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Anna Mitchell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho Falls Idaho

14. Informant Leavon Littlefield
(Address) Burley Ida

15. Filed Jan 22, 1929 Dr W H Coulter Registrar
Mrs Pierce

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Purpura Fulminans

(duration) yrs mos. ds.
CONTRIBUTORY (Secondary) Possibly infection from a bruise on the
(duration) yrs. Eleven mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) W H Coulter M. D.
Jan 8, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Dec. 8 1929
20. Undertaker	Address
D. E. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 26 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64936

PLACE OF DEATH.
County of Cassia
City of Burley Route 4

Registration District No. 17
Primary Registration District No. 2196
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

2. FULL NAME Joseph Rombach
(a) Residence. No. Burley, Route 4 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? 46 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Christiana Rombach

6. DATE OF BIRTH (month, day and year) Feb. 20, 1846

7. AGE: Years 82 | Months 11 | Days 19 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Baden Germany

PARENTS
10. NAME OF FATHER: Joseph Rombach
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs. Theresa Kimble
(Address) Burley Idaho R.F.D. 4

15. Filed Jan 22, 1929 Dr. O. H. Cutler Registrar
Mrs Greco

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 11th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1929, to Jan 11, 1929
that I last saw him alive on Dec 31st, 1929
and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows:
Final heart exhaustion; following 9 years of nervous instability. For last 6 months gradual failure following a stroke. (duration) ___ yrs. ___ mos. ___ ds.
CONTRIBUTORY (Secondary) apoplexy.
(duration) 9 yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Dr. G. E. Craner, M. D.
Jan 12, 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pleasant View, Burley | Date of Burial 19

20. Undertaker: P. J. Grossman | Address: Burley, Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 26 1929

RECEIVED FEB 26 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64937

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No. 117

Primary Registration District No. 2196

(No. .....)

Local Registrar's No. 3

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Orma Grace Brown

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Albert E Brown

6. DATE OF BIRTH (month, day and year) Sept. 25, 1882

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	3	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Minnesota
(State or country)

PARENTS

10. NAME OF FATHER Cyril G Bartlett

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Tomblinson

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country)

14. Informant Harold C. Brown

(Address) Burley Idaho RFD 4

15. Filed Jan 30, 1929 Dr W F Cutler Registrar
Mrs Greco

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12th, 1929, to Jan 12th, 1929, that I last saw h[illegible] alive on Jan 12th, 1929 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

- Peritonitis -

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) - Intestinal Obstruction

- (duration) - yrs. - mos. 2 - ds.

18. Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of Jan 8 - 1929

Was there an autopsy? No.

What test confirmed diagnosis? -

(Signed) Dr. H. Cooper - M. D.

Jan 26 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley	Jan. 16 1929

20. Undertaker	Address
D. E. Johnson	Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 26 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64938

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No. 117

Primary Registration District No. 2196

Local Registrar's No. 4

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Essie Horn

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 2, 1897

7. AGE Years 31 Months 3 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sublett Ida

PARENTS

10. NAME OF FATHER Daniel Horn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City Utah

12. MAIDEN NAME OF MOTHER Perssia Chambers

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spanish Fork Utah

14. Informant Daniel Horn

(Address) Sublett Ida.

15. Filed Jan 30, 1929 Dr H Cutler Registrar
Mrs Greco

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1929, to Jan. 19, 1929 that I last saw her alive on Jan. 19, 19.. and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan. 1. 29.

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) Joseph Fremstad D.

Jan. 30, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sublett Ida. Date of Burial Jan. 22 1929

20. Undertaker D. E. Johnson Address Burley

RECEIVED FEB 26 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64939

PLACE OF DEATH
County of Cassia
City of Oakley

Registration District No. 117
Primary Registration District No. 2196
(No. R. F. D. #1)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5

2. FULL NAME Berth Fairchilds Martin

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John S Martin

6. DATE OF BIRTH (month, day and year) Sept. 10, 1892

7. AGE Years 36 Months 4 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oakley Idaho

PARENTS
10. NAME OF FATHER John H Fairchilds
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Grantsville Utah
12. MAIDEN NAME OF MOTHER Louisa Anna McIntosh
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Grantsville Utah

14. Informant John S Martin
(Address) Oakley R. F. D. #1 Ida.

15. Filed Jan 30, 1929 Dr O H Cutler Registrar
Mrs Greco

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19, 1929 to Jan 22, 1929
that I last saw her alive on Jan 22, 1929
and that death occurred, on the date stated above, at 5:30 P. m.
The CAUSE OF DEATH* was as follows:
Intensive Flu
..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Myocarditis
..... (duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E Dean, M. D.
....., 19.... (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Oakley (Basin) Date of Burial 19

20. Undertaker D. E. Johnson Address Burley

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 26 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64940

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. 117
Primary Registration District No. 2196
(No.)
Local Registrar's No. 6
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Geneva Goold

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: George A Goold

6. DATE OF BIRTH (month, day and year): May 22, 1895

7. AGE: Years: 33 | Months: 8 | Days: | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Monroe Utah

PARENTS

10. NAME OF FATHER: Rowe Hicks
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Sarah Ann McCarty
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Geo A Goold
(Address): Burley Idaho

15. Filed Jan 30, 1929 Dr W H Hunter Registrar
Mrs Greco

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

A Puerperal Septicaemia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W H Hunter, M. D.
Jan 22, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Jan. 25 1929
20. Undertaker	Address
D. E. Johnson	Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 26 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64941

PLACE OF DEATH

County of Cassia
City of Oakley, Ida R#1

Registration District No. 117
Primary Registration District No. 2196
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

2. FULL NAME Frances Barber
(a) Residence. No. Oakley, Idaho R#1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Eva Humphrey Barber

6. DATE OF BIRTH (month, day and year) April 19, 1854

7. AGE: Years 74, Months 9, Days 8. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Brookville, Penn.

PARENTS

10. NAME OF FATHER: Jefferson Barber
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Rachel Barber
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn.

14. Informant: H. E. Bidgood
(Address) Oakley Ida R#1

15. Filed Jan 30, 1929. Dr. H. Cutler, Registrar
Mrs Greco

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19, 1929, to one visit, 19..., that I last saw him alive on Jan 19, 1929, and that death occurred, on the date stated above, at 1:15 A m.
The CAUSE OF DEATH* was as follows: as reported to me
Hypertension and Cardiac decompensation
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of
Was there an autopsy? —
What test confirmed diagnosis?
(Signed) H. B. Steward, M. D.
Jan 26, 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burley Cem. Date of Burial: Jan 28 1929

20. Undertaker: P. J. Grossman Address: Burley, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 28 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64942

PLACE OF DEATH

County of Cassia
City of Burley

Registration District No. 117
Primary Registration District No. 2196
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Thaddeus Lorenzo Ferrin

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 21, 1884

7. AGE Years 44 Months 5 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden Valley Utah

PARENTS

10. NAME OF FATHER Thaddeus Ferrin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden Ut.
12. MAIDEN NAME OF MOTHER Ann Nielsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Clovis Ferrin
(Address) Burley Idaho

15. Filed Jan 30, 1929 Dr A H Hutter Registrar
Mrs Greco

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26, 1929 to Jan 26, 1929
that I last saw him alive on Jan 26 29 - at 10 pm
and that death occurred, on the date stated above, at - 10 45 pm.
The CAUSE OF DEATH* was as follows:
Acute Valvular Heart Disease

— (duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) - Rheumatism

— (duration) yrs. 6 mos. — ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) G. H. Cooper, M. D.
Jan. 30, 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida. Date of Burial Jan. 29 1929

20. Undertaker D. E. Johnson Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 2 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64943

Local Registrar's No. 9

PLACE OF DEATH

County of Cassia

City of Declo

Registration District No. 117

Primary Registration District No. 2196

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arthur Lincoln Hull

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 10 1862

7. AGE: Years 66 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Zanesville Ohio

PARENTS

10. NAME OF FATHER: Wm H. Hull

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Zanesville Ohio

12. MAIDEN NAME OF MOTHER: Elezebeth Street

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio.

14. Informant: John Hull
(Address): Declo Idaho

15. Filed Jan 30, 1929 Dr W H Cutler Registrar
Mrs Grace

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) D. C. Johnson Coroner
Jan. 30, 1929 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Declo Ida — Date of Burial: Jan. 30 1929

20. Undertaker — Address

RECEIVED FEB 26 192[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64944

Registration District No. 117
Primary Registration District No. 2186
Local Registrar's No. 10

PLACE OF DEATH

County of Cassia
City of Burley
(No. 507 East Main Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Ellen Richardson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Widowed.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: William J Richardson
6. DATE OF BIRTH (month, day and year): Sept. 24, 1848
7. AGE: Years: 80 | Months: 4 | Days: 7 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....
9. BIRTHPLACE (city or town) (State or country): Jackson Co Missouri

PARENTS
10. NAME OF FATHER: Jacob Tevebaugh
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Fairfax Co Virginia
12. MAIDEN NAME OF MOTHER: Lucinda Howe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bath Co Virginia

14. Informant: S B Richardson
(Address) Declo Idaho

15. Filed: Feby 1, 1929 F H Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 31 (Month) (Day) 29 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1929, to Jan-31, 1929
that I last saw her alive on Jan-29, 1929
and that death occurred, on the date stated above, at 5:30 A.M.
The CAUSE OF DEATH* was as follows:
General debility and myocardial insufficiency
..... (duration) ..... yrs. 11 days mos.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of .....
Was there an autopsy? —
What test confirmed diagnosis?
(Signed) H.B. Stanger, M.
Jan 31, 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Oklahoma Co	Feb 6, 1929
20. Undertaker	Address
H. C. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64945

PLACE OF DEATH
County of Clark
City of Spencer

Registration District No. 125
Primary Registration District No. 2203

Local Registrar's No. 1

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Peter Lawson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 19. 1859

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	11	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) General store
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Peter Lawson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Mary Ohlen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Spencer Lawson
(Address) Spencer Idaho

15. Filed Feb 9, 1929 C E Jones M D
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Accidentally killed by locomotive

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) C E Jones, M. D.
Feb 9, 1929 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Spencer Idaho	Feb 10 1929
20. Undertaker V F McHan	Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64946

PLACE OF DEATH
County of Owyhee
City of Orofino

Registration District No. 70
Primary Registration District No. 768

Local Registrar's No. 18

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Hal Butzman

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) Orofino Idaho
(State or country)

PARENTS

10. NAME OF FATHER Hal Butzman
11. BIRTHPLACE OF FATHER (city or town) Caplinger Mills - Mo,
(State or Country)
12. MAIDEN NAME OF MOTHER Pearl Cook -
13. BIRTHPLACE OF MOTHER (city or town) Portland
(State or Country) Oregon

14. Informant Father
(Address) Orofino

15. Filed Mar 1, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 1 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19..., to ✓, 19...
that I last saw him alive on 1 - 29, 1929
and that death occurred, on the date stated above, at 8 a m.
The CAUSE OF DEATH* was as follows:
Not Known ✓

✓ (duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY ✓
(Secondary)
✓ (duration) ✓ yrs. ✓ mos. ✓ ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) H. F. Robertson, M. D.
2 - 1 -, 1929 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Feb 2- 1929

20. Undertaker W. D. Pinson — Address Orofino

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64947

PLACE OF DEATH
County of Orofino Clearwater
City of Orofino Ida
Registration District No. 90
Primary Registration District No. 2168
Local Registrar's No. 19
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Morsey

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

66

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years: about 52; Months; Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Road yarder
(b) General nature of industry, business, or establishment in which employed (or employer): Clearwater Timber Co.
(c) Name of employer: alone

9. BIRTHPLACE (city or town) (State or country): X

PARENTS
10. NAME OF FATHER: X
11. BIRTHPLACE OF FATHER (city or town) (State or Country): X
12. MAIDEN NAME OF MOTHER: X
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: W. L. Pinson
(Address): Orofino Ida

15. Filed Mar 1-, 1929. Dep V-A Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3rd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-30, 1929, to 2-3, 1929
that I last saw him alive on 2-3, 1929
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Pneumonia—

(duration) yrs. 5 mos. ds.
CONTRIBUTORY (Secondary) moonshine
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Pierce Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) M. F. Robertson, M. D.
2/3, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Feb 7 1929
20. Undertaker	Address
W. D. Pinson	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64948

Local Registrar's No. 90

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2168
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ada M. Bruyere

(a) Residence. No. ..... St. Sandpoint - Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of J. H. Bruyere

6 DATE OF BIRTH (month, day and year) March 13, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	10	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westfield, Massachusetts

PARENTS

10 NAME OF FATHER Addison Gage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Boston, Mass.

12 MAIDEN NAME OF MOTHER Mary Howe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Records: Northern Idaho Sanitarium - Orofino, Idaho.
(Address)

15 Filed Mar 1, 1929 Geo. V. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 3 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from November 28, 1927, to February 3, 1929, that I last saw her alive on February 3, 1929, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage (apoplexy)
..... (duration) ✓ yrs. ✓ mos. ✓ ds.
CONTRIBUTORY (Secondary) Psychosis with cerebral arterio-sclerosis (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs

(Signed) John Bruce McKelvey, M. D.
February 3 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	3/10 1929
20. Undertaker	Address
Geo. V. A. Shaw	Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64949

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2168
Local Registrar's No. 71
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dolores Verle Brandt

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 28 1929

7. AGE Years | Months | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Orofino Ida

PARENTS

10. NAME OF FATHER J.W. Brandt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Bessie Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mic

14. Informant J.W. Brindt
(Address) Orofino Ida

15. Filed Mar 1, 1929 N.A. Shaw Dep. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1929, to Feb 5, 1929
that I last saw her alive on Feb 5, 1929
and that death occurred, on the date stated above, at 11:30 m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical Findings
(Signed) O M Husted M. D.
2/5, 1929 (Address) Orofino Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino Ida
Date of Burial: 2/7 1929

20. Undertaker: N.A. Shaw
Address: Orofino

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64950

Local Registrar's No. 22

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2-68
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ellen Reed

(a) Residence. No. ..... St. Sandpoint - Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6 DATE OF BIRTH (month, day and year) February 24, 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	14	11	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Clark Forks, Idaho.

PARENTS
10 NAME OF FATHER Charles Reed
11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden
12 MAIDEN NAME OF MOTHER Sofia Espleine
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Records: Northern Idaho Sanitarium
(Address) Orofino, Idaho.

15 Filed Mar 1, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
February (Month) 9 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to February 9, 1929, that I last saw her alive on February 9, 1929, and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis -
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Psychosis with mental deficiency
(duration) 14 yrs. 11 mos. 15 ds.

18 Where was disease contracted ✓ if not at place of death?
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) John Irvine McKelvey, M. D.
February 9, 1929 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: No. Idaho San. Cemetery — Date of Burial: Feb. 12 1929
20. Undertaker: Tibbetts - Hosp. attat. — Address: Orofino, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64951

PLACE OF DEATH

County of Clearwater
City of Weippe

Registration District No. 90
Primary Registration District No. 2168
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 73

2. FULL NAME Sarah Marther Centers

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James Wesley Centers

6. DATE OF BIRTH (month, day and year) July 27 1856

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72	6	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Livonia Mo.

PARENTS

10. NAME OF FATHER: David Forbes
11. BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina
12. MAIDEN NAME OF MOTHER: Martha Richardson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn.

14. Informant: James W. Centers
(Address): Weippe Ida

15. Filed Mar 1 - , 1929 Jef. V. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Heart Trouble
No Doctor attended
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) ....., M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Weippe Ida
Date of Burial: Feb 13 1929

20. Undertaker: W. D. Pinson
Address: Orofino Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64952

PLACE OF DEATH

County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2168
Local Registrar's No. 24
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oscar Karbi

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE: Years: About 47; Months; Days; If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Lumber Jack
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Clearwater Timber Co
9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER: / M
11. BIRTHPLACE OF FATHER (city or town) (State or Country): M
12. MAIDEN NAME OF MOTHER: M
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Coroner W. A. Shaw
(Address) Orofino

15. Filed Mar 1, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 9A m.
The CAUSE OF DEATH* was as follows:
Accidental killed by a falling thee striking him in between the sholders and braking his neck
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. A. Shaw Coroner, M. D.
2/11, 1929 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino	Feb 14 1929
20. Undertaker: W. A. Shaw	Address: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64953

PLACE OF DEATH

County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2168

Local Registrar's No. 25

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maggie Esty Gardner

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Femal
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Vera Gardner

6. DATE OF BIRTH (month, day and year): Aug 13 1898

7. AGE: Years 30 | Months 5 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Tex

PARENTS

10. NAME OF FATHER: James Haden
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missiouri
12. MAIDEN NAME OF MOTHER: Maggie Sayling
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tex

14. Informant: Verna Gardner
(Address): Weippe Ida

15. Filed Mar 1, 1929. Def. N. A. Shaw, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1929, to Feb 12, 1929
that I last saw her alive on Feb 12, 1929
and that death occurred, on the date stated above, at 1.45 m.p.
The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Weippe Idaho
Did an operation precede death? No Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical & Laboratory Findings
(Signed) O M Husted M. D.
Feb 12, 1929 (Address) Orofino Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Weippe Ida | Date of Burial: Feb 14 1929

20. Undertaker: N. A. Shaw | Address: Orofino

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64954
Local Registrar's No. 26

PLACE OF DEATH

County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2168
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Carrie Forseth

(a) Residence. No. ..... St. Viola, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 21 yrs. 2 mos. 23 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sigvard M. Forseth

6 DATE OF BIRTH (month, day and year) Unascertained

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	55	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS
10 NAME OF FATHER John Christensen
11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway
12 MAIDEN NAME OF MOTHER Martha Knutsen
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Records; Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15 Filed Mar 1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 14 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to Feb. 14, 1929, that I last saw her alive on February 13, 1929, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:
Chronic endocarditis - mitral regurgitation -
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Dementia praecox - paranoid type.
(duration) 22 yrs. + mos. + ds.

18 Where was disease contracted ✓ if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John Howe McKelvey - M. D.
February 14 1929 (Address) Orofino - Idaho -

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	2/17 1929
20. Undertaker	Address
W. A. Shaw	Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 64955

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 768

(No. Northern Idaho Sanitarium)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 27

2. FULL NAME T. B. Gonyea

(a) Residence. No. ..... St. Wallace, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6 DATE OF BIRTH (month, day and year) Unascertained

7 AGE: Years 75 | Months ? | Days ? | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER Unascertained

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unascertained

12 MAIDEN NAME OF MOTHER Unascertained

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unascertained

14 Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15 Filed Mar 1, 1929 Dep. N. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February (Month) 14 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to Feb. 14, 1929, that I last saw him alive on February 14, 1929, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

..... (duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Psychosis with Cerebral Syphilis

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted ✓
If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Wassermann positive

(Signed) John Irvine McKelvey, M. D.

February 14 1929 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: No. Idaho San. Cemetery

Date of Burial: Feb. 15 1929

20. Undertaker: McGrew, Hospital attdt.

Address: Orofino, Idaho.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64956

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2168
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 28

2. FULL NAME Lola M. Dodge

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	1	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9. BIRTHPLACE (city or town) Orofino
(State or country) Ida

PARENTS

10. NAME OF FATHER Edgar Dodge
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Vermont
12. MAIDEN NAME OF MOTHER Hattie Sullivan
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Ida

14. Informant Ed Dodge
(Address) Orofino Ida

15. Filed Mar 1, 1929. Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 18th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1929, to Feb. 18, 1929
that I last saw her alive on Feb. 17, 1929
and that death occurred, on the date stated above, at 5:00 a. m.
The CAUSE OF DEATH* was as follows:

Anterior poliomyelitis, acute

(duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Spinal puncture

(Signed) R. S. Hopkins, M. D.
2/18, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverside Cemet	Feb 20. 1929
20. Undertaker	Address
W. D. Pinson	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64957

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 9168

Local Registrar's No. 24

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas A Richards

(a) Residence. No. _____ St. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Anna Richards

6. DATE OF BIRTH (month, day and year) April 19 1884

7. AGE Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
44	10	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) (State or country) Orgen

PARENTS

10. NAME OF FATHER Lester Richards

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ?

12. MAIDEN NAME OF MOTHER Anna Robinson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ?

14. Informant Mrs Anna Richards
(Address) Piersc Ida

15. Filed Mar 1 1929 Deputy W A Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1929, to Feb 22, 1929
that I last saw h~~im~~ alive on Feb 21, 1929
and that death occurred, on the date stated above, at 6 A m.
The CAUSE OF DEATH* was as follows:

Hodgkens Disease

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

_____ (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? Oregon
Did an operation precede death? no Date of _____
Was there an autopsy? no
What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) O M Sweet, M. D.
Feb 22, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Feb 28 1929

20. Undertaker W A Shaw — Address Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 9 1929

PLACE OF DEATH

County of Clearwater

City of Orofino

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 168

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64958

Local Registrar's No. 30

2. FULL NAME Nel O Helgerson

(a) Residence. No. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Whiet

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizbath Helgeerson

6. DATE OF BIRTH (month, day and year): Dec 18 1882

7. AGE: Years 46 | Months 2 | Days 7 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Hotel Keeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Minn

PARENTS

10. NAME OF FATHER: L Helgerson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Lena

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wis

14. Informant: Mrs Helgerson

(Address): Orofino

15. Filed Mar 1, 1929. Jeff V. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1929, to Feb 25, 1929, that I last saw him alive on Feb 25, 1929, and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction — (Fibrous band of adhesion surrounding loop of ileum).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Appendicitis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) O M Dusted M. D.

2/25, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino Ida — Date of Burial: Mar 1 1929

20. Undertaker: W. A. Shaw — Address: Orofino

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
64959
State File No.

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 9
Primary Registration District No. 8
(No. Northern Idaho Sanitarium)
Local Registrar's No. 31
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Lona May Tregoning

(a) Residence. No. ..... St. Wardner, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? 30 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6 DATE OF BIRTH (month, day and year) Unascertained

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cornwall. England

PARENTS
10 NAME OF FATHER Dan Tregoning
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unascertained
12 MAIDEN NAME OF MOTHER Unascertained
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unascertained

14 Informant Records: Northern Idaho Sanitarium.
(Address) Orofino - Idaho.

15 Filed Mar 1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Febrvary 27 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to Febrvary 27, 1929, that I last saw her alive on Febrvary 27, 1929, and that death occurred, on the date stated above, at 5:2 P. m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
..... (duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Tuphosis with mental deficiency
..... (duration) 32 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John Irvine McElvaney, M. D.
Feb. 27, 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: No. Idaho San. Cemetery — Date of Burial: Feb. 28 1929
20. Undertaker: F. A. Dillberg, Hosp. Attd. — Address: Orofino - Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64960

PLACE OF DEATH RECEIVED MAR 11
County of Clearwater
City of Elk River
Registration District No. 21
Primary Registration District No. 2168
Local Registrar's No. 1
(No. Elk River Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas J. Hennessy
(a) Residence. No. St. St. Maries, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. T. J. Hennessy.

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer) C. M. & St P. Railroad
(c) Name of employer C. M. & St. P.

9. BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS

10. NAME OF FATHER Thos Hennesdy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Conn.
12. MAIDEN NAME OF MOTHER Katherine Curley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mrs T J Hennessy
(Address) St Maries Ida

15. Filed Mar. 8, 1929 Mildred L. Hamby
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-3-, 1929, to 2-7-, 1929
that I last saw him alive on 2-7-, 1929
and that death occurred, on the date stated above, at 5:55 a. m.

The CAUSE OF DEATH* was as follows:
Injury by fall from car causing internal kidney trauma, hemorrhage,
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Shock, hemorrhage from kidney, fracture R. leg (duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & X-Ray.
(Signed) Fred Caraway M. D.
Feb 7, 1929 (Address) Elk River, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Kanesburo Minn	
20. Undertaker O'Meraga St Maries	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64961

Local Registrar's No. 20

PLACE OF DEATH

County of Franklin

City of Weston

Registration District No. 27

Primary Registration District No. 2119

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Otto Gassman

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emlie Catherine Gassman

6. DATE OF BIRTH (month, day and year) July 6 1862

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	06	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Providence Utah

PARENTS

10. NAME OF FATHER Henry Gassman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Catherine Knople

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Mrs Emliy Gassman
(Address) Weston Idaho

15. Filed 3-2, 1929 C. R. Wells Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1928, to Jan 30, 1929
that I last saw him alive on Jan 30, 1929
and that death occurred, on the date stated above, at 1.30 P m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos O Holden, M. D.

2/6, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Weston Idaho	Feb. 8 29
20. Undertaker M. W. Hendricks	Address Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64962

PLACE OF DEATH

County of Franklin
City of Dayton

Registration District No. 27
Primary Registration District No. 2119
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15

2. FULL NAME David Lavon Toothman

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 13 1929

7. AGE Years Months Days If LESS than 1 day, 1 hrs. or min.

8. OCCUPATION OF DECEASED baby
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dayton Idaho

PARENTS

10. NAME OF FATHER John Toothman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montrose Call.

12. MAIDEN NAME OF MOTHER Verda Smith

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dayton

14. Informant Verda Smith Toothman
(Address) Daton

15. Filed 3-2, 1929 F. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febr. (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr. 13, 1929 to Febr. 13, 1929
that I last saw him alive on Febr. 13, 1929
and that death occurred, on the date stated above, at 12 40 p.m.
The CAUSE OF DEATH* was as follows: Premature birth

(duration) — yrs. ✓ mos. 1 ds.

CONTRIBUTORY (Secondary) ✓

(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) G. W. States, M. D.
Febr. 14, 1929 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Dayton Idaho
Date of Burial: Feb 13 29 19

20. Undertaker
Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1929

PLACE OF DEATH

County of Franklin

City of Daton

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 27

Primary Registration District No. 2119

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64963

Local Registrar's No. 14

2. FULL NAME Naomia Jean Jones

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 12 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Daton Idaho

PARENTS

10. NAME OF FATHER Manon Jones D

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Daton Idaho

12. MAIDEN NAME OF MOTHER Elda L Jensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ephriam Ut

14. Informant Chas. Jones
(Address) Daton Idaho

15. Filed 3-2, 1929 A. L. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend, 19

that I last saw h alive on, 19

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Not determined Was found dead when parents awoke.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. L. Cutler, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Daton Idaho — Date of Burial: Feb 9 29 19

20. Undertaker: M. W. Hendricks — Address: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64964

PLACE OF DEATH

County of Franklin

City of ~~Franklin~~

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No. 13

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Philip Wre n Holden

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: whiten

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Apr 27 1927

7. AGE: Years 1 Months 19 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Franklin

PARENTS

10. NAME OF FATHER: Enos Holden

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Whitney Idaho

12. MAIDEN NAME OF MOTHER: Hazel Kingsford

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Cove Utah

14. Informant: Enos Holden
(Address): Franklin Idaho

15. Filed 3. 2, 1929 A. R. Little Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF ~~DEATH~~ Feb. 18 1929
(Month) (Day) (Year)

17. I ~~HEREBY~~ CERTIFY, That I attended deceased from ~~Feb~~ 19 to 19
that I last saw him alive on never saw him alive 19
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows: Foreign Body lodged in Trachea (Accidental) (duration) yrs. 10 minutes mos. ds.

CONTRIBUTORY (Secondary) ——
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Dorley, M. D.

Feb 18, 1929 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Franklin Idaho
Date of Burial: Feb 20 1929

20. Undertaker
Address

RECEIVED MAR 6 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Registration District No. 27
Primary Registration District No. 2119
State File No. 64965
Local Registrar's No. 79

1. PLACE OF DEATH
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.
(No. ..... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John M Parry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Divorced
6. DATE OF BIRTH: June 24 1869 (Month) (Day) (Year)
7. AGE: 69 Yrs. ..... Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Musician
(b) General nature of industry, business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Utah
10. NAME OF Father: John Perry
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Harriet Roberts
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Nielsen
(Address) Preston Idaho
15. Filed 3-2 1929 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr (Month) 2 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 1928 to Febr 2 1929, that I last saw him alive on Febr 1 1929, and that death occurred on the date stated above, at 6 A M.
The CAUSE OF DEATH* was as follows:
Carcinoma of throat
(Duration) — yrs. 6 mos. — ds.
Contributory (Secondary) Diabetis
(Duration) Several yrs. — mos. — ds.
(Signed) Geo. Staley M. D.
(Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Logan, Utah — DATE OF BURIAL 19 .....
20. UNDERTAKER [illegible] — ADDRESS Logan, Utah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1929

PLACE OF DEATH

County of Franklin

City of Preston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 27

Primary Registration District No. 2119

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64966

Local Registrar's No. 18

2. FULL NAME Sarah J. Schuldberg

(a) Residence. No. ..... St. .....

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Wm. Schuldberg

6. DATE OF BIRTH (month, day and year): June 22 1879

7. AGE — Years: 47 | Months: 5 | Days: 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Hydepark Utah

PARENTS

10. NAME OF FATHER: Hanse Peter Jensen

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Cecilia Thompson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Wm. Schuldberg

(Address): Winder Idaho

15. Filed 3-2, 1929 — A. R. Cutler, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-20, 1929, to 2-6, 1929, that I last saw h[er] alive on 2-6, 1929, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows: Chronic interstitial Nephritis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Pregnancy.

(duration) ..... yrs. 7 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) A. R. Cutler, M. D.

....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho — Date of Burial: Feb. 10 1929

20. Undertaker: M. W. Hendricks — Address: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 6 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64967

County of Franklin

City of Preston

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No. 12

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gibson R. Condie

(a) Residence. No. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ettie Condie

6. DATE OF BIRTH (month, day and year) Sept 12 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	5	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake City

PARENTS

10. NAME OF FATHER Gibson Condie

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Elizabeth Robinson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs. Gibson R. Condie

(Address) Preston Idaho

15. Filed 3-2, 1929 A. R. Cuiley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-2, 1929, to 2-18, 1929 that I last saw h[illegible] alive on 2-14, 1929 and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) General arteriosclerosis

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. R. Cuiley, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Feb. 20 1929

20. Undertaker	Address
M. W. Hendricks	Preston Id ho

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64968

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No. 16
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wayne Shay

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Nov. 19 28

7. AGE: Years | Months: 2 | Days: 21 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED: Baby
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Salt Lake City Utah

PARENTS

10. NAME OF FATHER: Joseph Shay
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Leah Allred
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Lewiston Utah

14. Informant: Wm. Allred
(Address): Preston Idaho

15. Filed 3-2, 1929 — C. R. Mullen, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-10, 1929, to 2-10, 1929
that I last saw him alive on 2-10, 1929
and that death occurred, on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Mutral Insufficiency
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) E. S. Milford, M. D.
2-11, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Feb 12 1929

20. Undertaker: M. W. Hendricks — Address: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64969

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

2. FULL NAME David Cullins Eames

(a) Residence. No. _____ St. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Eames

6. DATE OF BIRTH (month, day and year) Sept 1 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	76	5	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Salt Lak City
(State or country) Utah

PARENTS

10. NAME OF FATHER David Eames
11. BIRTHPLACE OF FATHER (city or town) England / Wales
(State or Country)
12. MAIDEN NAME OF MOTHER Esther Cullins
13. BIRTHPLACE OF MOTHER (city or town) England
(State or Country)

14. Informant Mrs Lilly Benson
(Address) Preston Idaho

15. Filed 3-2, 1929 A. P. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-, 1928, to 2-9, 1929
that I last saw h[illegible] alive on 2-8, 1929
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial nephritis Uremia
(duration) _____ yrs. 2 mos. _____ ds.
CONTRIBUTORY (Secondary) Cystitis - Suprapubic Aspiration
(duration) 3 yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? _____
(Signed) A. P. Cutler, M. D.
_____, 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Feb. 13 29

20. Undertaker	Address
M & W Hendricks	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64971

PLACE OF DEATH
County of Fremont
~~City of~~ Rea Idaho

Registration District No. 102
Primary Registration District No. 6
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Arthur Uden
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: Elizabeth Uden

6. DATE OF BIRTH (month, day and year): May 30th 1867

7. AGE: Years 61, Months 8, Days 19. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Road House Owner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS
10. NAME OF FATHER: William Uden
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Dis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs Elizabeth Uden
(Address) ~~as~~ Rea Idaho

15. Filed 1-21, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 19th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 230 P.M.
The CAUSE OF DEATH* was as follows: Dont Know
Died with out medical attention
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: St Anthony Idaho — Date of Burial: 1-21 1929

20. Undertaker: Lewis Kiser — Address: Ashton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

R[illegible] FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64972

PLACE OF DEATH

County of FREMONT

City of ASHTON

Registration District No. 102

Primary Registration District No. 6

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME FRANK M. McGAVIN.

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) JULY 13th 1926

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	5	27	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work AT HOME

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ASHTON IDAHO

PARENTS

10. NAME OF FATHER FRANK McGAVIN

11. BIRTHPLACE OF FATHER (city or town) (State or Country) IDAHO

12. MAIDEN NAME OF MOTHER INEZ. CUNNINGHAM

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UTAH

14. Informant Mrs. INEZ McGAVIN

(Address) ASHTON IDAHO

15. Filed 1-14, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JANUARY 11th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9, 1929, to Jan 11, 1929
that I last saw h[illegible] alive on Jan 11, 1929
and that death occurred, on the date stated above, at 2 A. M. m.
The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs 8 mos. ds.

18. Where was disease contracted ✓ if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) [signature] M. D.
Jan 14, 1929 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
ASHTON IDAHO	1/14/29 19

20. Undertaker L. I. KISER Address ASHTON Idaho

[illegible] KISER

RECEIVED FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64973

PLACE OF DEATH
County of Fremont
City of Ashton

Registration District No. 102
Primary Registration District No. 6
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Alice Leona Hansen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) —
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) July 19th 1928
7. AGE Years Months 6 Days 8 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ashton Idaho

PARENTS
10. NAME OF FATHER Norman Hansen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Grant Idaho
12. MAIDEN NAME OF MOTHER Alice Vandrestedin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hartford Conn

14. Informant Mrs Norman Hansen
(Address) Ashton Idaho
15. Filed 1-27, 1929 A C Meacham Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 26 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to Jan 26, 1929
that I last saw her alive on Jan 26, 1929
and that death occurred, on the date stated above, at 2 P.M. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. 11 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) E. V. Hargis, M. D.
Jan 29, 1929 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Ashton Idaho — Date of Burial 1-29 1929
20. Undertaker Lewis Kiser — Address Ashton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64974

PLACE OF DEATH
County of Fremont
City of Ashton

Registration District No. 102
Primary Registration District No. 6

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth Uden

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 26th 1902

7. AGE Years 26 Months 2 Days 26 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake city Utah

PARENTS
10. NAME OF FATHER Geo. Arthur Uden
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth French
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs. Elizabeth Uden
(Address) Rea Idaho

15. Filed 1-24, 1929 C. Meeshan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 23rd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1929, to Jan 23, 1929
that I last saw her alive on Jan 23, 1929
and that death occurred, on the date stated above, at 5:30 A.M.
The CAUSE OF DEATH* was as follows:
Concussion of brain due to injury.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Patient an Idiot.
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E. L. Hargis, M.D.
Jan 24, 1929 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St Anthony Idaho — Date of Burial 1-24 1929

20. Undertaker Lewis Kiser — Address Ashton Idaho

MARGIN RESERVED FOR BINDING Mar 14 Apr 11

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Dear Doctor: May we please have this information?

March 19, 1929.

APR 17 1929

apr 11-1929.

Second request.

Dr. E. L. Hargis,

Ashton, Idaho. Re: 44974

Dear Doctor:

In order to comply with the requirements of the U. S. Census Bureau will you kindly give us some further information in order to complete the death certificate of RUTH UDEN who died January 23rd, 1929.

You gave as the cause of death: "Concussion of brain due to injury".

Will you kindly advise WHAT KIND OF AN ACCIDENT was the primary cause of death.

An addressed stamped envelope is enclosed for your convenience in making reply.

Respectfully yours,

C. K. Macey

C. K. Macey,
State Registrar.

ANSWER BELOW & RETURN:

Ashton Idaho 4-15-29

Mr. C. K. Macey,
Boise, Idaho

Dear Sir:- Ruth Uden died from injury self inflicted. She would sit or stand up and throw herself backward violently. She perhaps threw her head against bed. No one saw her do it.

Yours truly,

E. L. Hargis

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64980

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No.
Primary Registration District No. 6
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph N. Demasters

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 27-1850

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	—	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lafayette Co. Missouri

PARENTS

10. NAME OF FATHER Jose Demasters
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Mary Ann Noval
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant J. H. Demasters
(Address) Ola Idaho

15. Filed 2/27, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 5, 1929, to Feby 25, 1929
that I last saw him alive on Feby 24, 1929
and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:
Suppurative cystitis
following influenza
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Hypertrophied prostate
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) C. D. Buckenum M. D.
2/27, 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ola, Idaho	2/27 1929
20. Undertaker C. D. Buckenum	Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64982

PLACE OF DEATH

County of Gem
City of Emmett
Registration District No. 6
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary S. Coulson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Feb 20 ✻

7. AGE Years	Months	Days	If LESS than 1 day, 36 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) Emmett
(State or country)

PARENTS

10. NAME OF FATHER Henry Kergard
11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Lola Coulson
13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant J R Coulson
(Address) Emmett

15. Filed 2/22, 1929 J. L. Reynolds
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1929, to Feb 21, 1929
that I last saw him alive on Feb 21, 1929
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. L. Reynolds, M. D.
2/22/1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	2/23/1929
20. Undertaker	Address
Case	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1939

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64983

Registration District No. 6
Primary Registration District No. 6
Local Registrar's No.

PLACE OF DEATH
County of Gem
City of Emmett
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Campbell

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant H. Hosler
(Address) Emmett Ida

15. Filed 3/25, 1939 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23, 1929, to Feb 23, 1929
that I last saw him alive on Feb 23 - , 1929
and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
aorta Myocardial disease
This was a sudden death
Fell on street and died
within few minutes (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. L. Reynolds M. D.
3/25, 1939 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Paxton Neb.	

20. Undertaker C. Bucknum — Address Emmett Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1929

PLACE OF DEATH

County of Gem

City of Emmett

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64984

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nettie E. McConchie

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas McConchie

6. DATE OF BIRTH (month, day and year): Mar 22-1871

7. AGE: Years 57, Months 10, Days 28. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Irving Kansas

PARENTS

10. NAME OF FATHER: Aaron Van Akin

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Mary Ann Fuller

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New Jersey

14. Informant: Martha V. Guthrie

(Address): Letha - Idaho.

15. Filed 2/22, 1929 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1928, to Feby 20, 1929 that I last saw her alive on Feby 9, 1929 and that death occurred, on the date stated above, at 1:45 P m.

The CAUSE OF DEATH* was as follows: myocardial insufficiency

(duration) 2 or 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic valvular disease

(duration) 2 or 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Kansas

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) R N Cummings, M. D.

2/22, 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Frankfort Kan

Date of Burial: 19

20. Undertaker: C D Bucknum

Address: Emmett Idaho

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64985

Registration District No.
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH

County of Gem
City of Montour
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gustave Hammar

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	—	—	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS

10. NAME OF FATHER August Hammar
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden
12. MAIDEN NAME OF MOTHER Bertie Larsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant O J Hammar
(Address) Ola Idaho

15. Filed 3/4, 1929 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to , 19
that I last saw him alive on July 15, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Gastric Carcinoma

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) C R Emmett M. D.
3/4, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ola, Idaho	3/4 1929
20. Undertaker O D Bucknum	Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64986

PLACE OF DEATH
County of Ada
City of Emmett

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Duane Bretal Thorning

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 23 - 1919

7. AGE	Years	Months	Days	If LESS than 1 day,
	9	7	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Emmett
(State or country) Idaho

PARENTS

10. NAME OF FATHER Chris H. Thorning
11. BIRTHPLACE OF FATHER (city or town) Denmark
(State or Country)
12. MAIDEN NAME OF MOTHER Lillian Bretal
13. BIRTHPLACE OF MOTHER (city or town) Roseburg
(State or Country) Oregon

14. Informant Lillian Thorning
(Address) Emmett Idaho

15. Filed 2/12, 1929 J. V. Reynolds
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 4, 1929, to Feby 9, 1929
that I last saw him alive on Feby 9, 1929
and that death occurred, on the date stated above, at 9 20 a m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) R. P. Cummings, M. D.
2/12, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 2/12 1929
20. Undertaker: O. D. Bucknum — Address: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64987

Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. .....

PLACE OF DEATH

County of Gem
City of Emmett
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Francis Washington Reed

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harriet E. Reed

6. DATE OF BIRTH (month, day and year) May 3rd 1854

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	9	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Fremont Michigan
(State or country)

PARENTS

10. NAME OF FATHER Sylvanus Reed
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) New York State
12. MAIDEN NAME OF MOTHER Harriet Barnhard
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Ohio

14. Informant F. R. Chapin
(Address) Emmett Idaho

15. Filed 2/24, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19th, 1929, to Feb 21, 1929
that I last saw him alive on Feb 19, 1929
and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:
Diabetic Coma
Diabetis Mellitus
(duration) several yrs. mos. ds.

CONTRIBUTORY .....
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) J. L. Reynolds, M. D.
2/24, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	2/24 1929
20. Undertaker C. D. Buckner	Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 8 1929

PLACE OF DEATH

County of Gem

City of Emmett

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

DO NOT WRITE IN THIS SPACE

State File No. 64988

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lorina Viola Streeter

(a) Residence. No. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: R C Streeter

6. DATE OF BIRTH (month, day and year): Aug 1 - 1856

7. AGE: Years: 72 | Months: 5 | Days: 28 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Burnette Wis

PARENTS

10. NAME OF FATHER: Samuel J Glover

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Russell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): not known

14. Informant: Mrs P R Miles

(Address): Emmett Idaho

15. Filed 1/31, 1929 J C Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1928, to Jan 27, 1929

that I last saw her alive on Jan 27, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ischio rectal abscess with fistula

(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L N Emmett M. D.

1/31, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Ida — Date of Burial: 1/31 1929

20. Undertaker: C D Buckmann — Address: Emmett Idaho

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64989

Local Registrar's No. 11

Registration District No. .....
Primary Registration District No. .....
(No. .....)

PLACE OF DEATH

County of Cassia
City of Oakley

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mary Stoper

(a) Residence. No. Oakley Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day and year) Feb 3 - 29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
				10 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Oakley Idaho

PARENTS
10 NAME OF FATHER Mayo Stoper
11 BIRTHPLACE OF FATHER (city or town) (State or country) Idaho
12 MAIDEN NAME OF MOTHER Mary Overson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah

14 Informant Mayo Stoper
(Address) Oakley Idaho

15 Filed March 1, 1929 A. D. Nielson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 3 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 3rd, 1929, to Feb 3, 1929,
that I last saw h[illegible] alive on Feb 3, 1929,
and that death occurred, on the date stated above, at 4 [illegible] m.

The CAUSE OF DEATH* was as follows:
Premature baby
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Trauma thru mother
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) A. D. Nielson, M. D.
Feb 4, 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Oakley Id
Date of Burial Feb 4 1929

20. Undertaker Mayo Stoper
Address Oakley Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-2 RECEIVED MAR 7 [illegible]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 64990

Registered No. 121

1. PLACE OF DEATH

County of Gooding

City of Gooding (No. 24 St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elfa Story

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married

6. DATE OF BIRTH

(Month) (Day) 1 (Year)

7. AGE

37 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Meigs Co. Ohio

10. NAME OF FATHER John Casey

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse J. Story Husband

(Address) Gooding Ida

15.

Filed 2/28 1929

J. H. Cromwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1928 to Feb 17 1929 that I last saw her alive on Feb 17 1929, and that death occurred on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor

(Duration) Yrs. 4 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. Russell Evans M. D.

Feb 28 1929 (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gooding Ida	2-19 1929

20. UNDERTAKER	ADDRESS
T. E. Thompson	Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5 RECEIVED MAR 7 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lincoln

City of Tunupa

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 24

(No. , St.)

File No. 64991

Registered No. 120

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Artis May Attebury

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 8 (Day) 1929 (Year)

7. AGE: Yrs. Mos. 2 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Gooding Co Ida

10. NAME OF FATHER: John J. Attebury

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Senora O Spencer

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John J. Attebury

(Address)

15. Filed 2/28 1929

J H Cromwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 8 1929, to Feb. 9 1929, that I last saw her alive on Feb. 9 1929 and that death occurred on the date stated above, at 2:30 a. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Houston E Snyder M. D.

2-11 1929 (Address) Gooding Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Idaho

DATE OF BURIAL: 2-12 1929

20. UNDERTAKER: A. E. Thompson

ADDRESS: Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64992

PLACE OF DEATH
County of Idaho
City of Clearwater

Registration District No. 106
Primary Registration District No. 2184
Local Registrar's No. 269

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Yrona Clementine Campbell

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Jackson Campbell

6. DATE OF BIRTH (month, day and year) October-14-1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fayetteville - Arkansas

PARENTS

10. NAME OF FATHER William Watts
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont-Know
12. MAIDEN NAME OF MOTHER Celia Stout
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont-Know

14. Informant Ed Talbott
(Address) Clearwater - Idaho.

15. Filed Feb 13, 1929 J M Vanderkooi Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1929, to Feb 12, 1929
that I last saw her alive on Feb 10, 1929
and that death occurred, on the date stated above, at 9:30 a.m.
The CAUSE OF DEATH* was as follows:
Chronic diffuse Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Valvular heart disease
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. M. Vanderkooi M. D.
Feb 13, 1929 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clearwater Cemetery	Feb 13 1929
20. Undertaker	Address

RECEIVED FEB 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64993

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 267

2. FULL NAME John Emery Haight

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Nov-6-1923

7. AGE Years 3 Months 2 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ~~Inf~~ Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER John Haight
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Vena Nicholson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant John J. Haight
(Address) Kooskia

15. Filed Feb 1, 1929 J M Verbeekmans Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan-23 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-25, 1929, to Jan, 1929
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 1:30 P m.
The CAUSE OF DEATH* was as follows:
Scarlet Fever

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J. M. Verbeekmans, M. D.
Jan 25, 1929 (Address) Kooskia Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kooskia Cemetery
Date of Burial Jan-25 1929

20. Undertaker
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64994

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
Local Registrar's No. 266

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Aldine Smith

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Smith

6. DATE OF BIRTH (month, day and year)

7. AGE: Years: About - 80; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Schoolteacher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): N. Y.

PARENTS
10. NAME OF FATHER: Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country): "
12. MAIDEN NAME OF MOTHER: "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Ben Capwell
(Address) Kooskia - Idaho

15. Filed Feb 1, 1929. J M Verbeekmans Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Jan 19, 1929
that I last saw him alive on ....., 19....
and that death occurred, on the date stated above, at 10:30 a.m.
The CAUSE OF DEATH* was as follows:
Influenza

..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Chronic Valvules heart-disease
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J M Verbeekmans, M. D.
Jan 23, 1929 (Address) Kooskia

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kooskia Cemetery
Date of Burial: Jan. 23 1929

20. Undertaker: Geo Frenary - J
Address: Kooskia

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 1 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64995

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184

Local Registrar's No. 268

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Samuel Engle

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Engle

6. DATE OF BIRTH (month, day and year) Nov. 27 1853

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Muskegan

PARENTS

10. NAME OF FATHER Miles Engle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania
12. MAIDEN NAME OF MOTHER Mary Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pennsylvania

14. Informant Thos. E. Engle
(Address) Kooskia — Idaho

15. Filed Feb 1, 1929 — J. M. Verbeck Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 5 30 p m.

The CAUSE OF DEATH* was as follows:
No medical Attendant —
Died suddenly. probably Heart-
disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. M. Verbeck M. D.
Jan 27, 1929 (Address) Kooskia

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kooskia Cemetery	Jan 27 1929
20. Undertaker	Address
Geo. Tamney	Kooskia Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64996

Local Registrar's No. 1

RECEIVED FEB 15 1929

PLACE OF DEATH

County of Jefferson.

City of Rigby.

Registration District No. 98

Primary Registration District No. 2176

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Thomas Harris.

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug. 12, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Thomas Harris.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Maria Hadley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Chas. Doman.

(Address) Rigby, Idaho

15 Filed 2-1, 1929 A. K. Larsen Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January (Month) 16 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1-1, 1929, to 1-16, 1929, that I last saw h. alive on 1-15, 1929, and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) M. D.

1-18, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rigby, Idaho

Date of Burial: 1/20/29

20. Undertaker: A. B. Eckersell

Address: Rigby.

RECEIVED FEB 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 64997

PLACE OF DEATH

County of Jefferson.

City of Rigby.

CERTIFICATE OF DEATH

Registration District No. 98

Primary Registration District No. 2126

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 2

2. FULL NAME Hazel (Glenn) Barrow.

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F. M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced ~~XXXXXXXX~~ (or) WIFE of John A. Barrow.

6 DATE OF BIRTH (month, day and year) April 6 1895

7 AGE: Years 35 | Months 8 | Days 29 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Utah.

PARENTS

10 NAME OF FATHER J. E. Glenn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Utah.

12 MAIDEN NAME OF MOTHER Annie E. Hanson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah.

14 Informant John A Barrow.

(Address) Box #64 Rigby, Idaho.

15 Filed 2-1, 1929 C. A. Tarin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 4th 1929 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1928, to Jan 1st, 1929, that I last saw her alive on Jan 1st, 1929, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease

Cardiac Dilatation

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual diagnostic methods

(Signed) H. A. Anderson, M. D.

Jan 5th, 1929 (Address) Rigby - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rigby, Idaho.

Date of Burial: 1/7/28 19

20. Undertaker: A B Eckersell

Address: Rigby.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64998

Local Registrar's No. 3

PLACE OF DEATH

County of Jefferson
City of Rigby.
Registration District No. 98
Primary Registration District No. 2176
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Herbert Neshoba Parks.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of [redacted] Jane Elizabeth Parks.

6 DATE OF BIRTH (month, day and year) March 26 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	9	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Wm. Waitsell Parks.
11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.
12 MAIDEN NAME OF MOTHER Eliza Ann Corpening.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Jane E. Parks
(Address) Rigby, Idaho. R. #1

15 Filed 2-1, 1929 C. A. Gavin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January (Month) 13 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from on Jan 12th, 1929, to ✓, 19✓,
that I last saw h... alive on , 19,
and that death occurred, on the date stated above, at 1 4 m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
sudden (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. A. Anderson, M. D.
, 19 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rigby, Idaho — Date of Burial: 1/16/29 19

20. Undertaker: C. E. Eckersell — Address: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED [illegible] 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 64999

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Jefferson
City of Rigby.

Registration District No. 98
Primary Registration District No. 2176
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 4

2. FULL NAME Alfred Boram

(a) Residence. No. Rigby, Idaho R #1. St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of~~ Mary A, Boram.

6 DATE OF BIRTH (month, day and year) Feb. 2,1836

7 AGE: Years 92 | Months 11 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) England

PARENTS
10 NAME OF FATHER Wm. Boram
11 BIRTHPLACE OF FATHER (city or town) (State or country) England.
12 MAIDEN NAME OF MOTHER Elizabeth Angel.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Mrs. Mary A. Boram.
(Address) Rigby, Idaho R. #1.

15 Filed 2-1, 1929 C H Tavin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 10 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Jan 10, 1929, that I last saw him alive on Jan 1, 1929, and that death occurred, on the date stated above, at 9a. m.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis,
Myocarditis,
..... (duration) 20 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C H Tavin, M. D.
1-10, 1929 (Address) Rigby

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Clarkston, Utah
Date of Burial: 1/13/29 19

20. Undertaker: A B Eckersell
Address: Rigby.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65000

PLACE OF DEATH
County of Jefferson.
City of Rigby

Registration District No. 98
Primary Registration District No. 2176
(No.)
Local Registrar's No. 5

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Keith Wren

(a) Residence. No. Rigby R. #3 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept 6 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10 NAME OF FATHER J. F. Wren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kansas

12 MAIDEN NAME OF MOTHER Eltha Ricks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho.

14 Informant Mr. J. F. Wren.
(Address) Rigby, Idaho. R #3

15 Filed 2-1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 9 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1929, to Jan 9, 1929, that I last saw h-m alive on Jan 9, 1929, and that death occurred, on the date stated above, at 2:10 p m.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia
Acute pulmonary congestion
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) [signature] M. D.
Rigby (Address) 1-10-29

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Sugar City, Ida	1/12/29

20. Undertaker [signature] Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED [illegible] 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65001

Local Registrar's No. 6

County of Jefferson

City of Rigby

Registration District No. 98

Primary Registration District No. 2176

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Dorthy Doris Noreen.

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Babe.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. 13, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
	0	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rigby, Idaho.

PARENTS

10 NAME OF FATHER Theadore Casey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Mamie Noreen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rigby, Idaho.

14 Informant Miss Mamie Noreen

(Address) Rigby, Idaho.

15 Filed 2-1, 1929 C A Larsen
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 16 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1928, to Jan 16, 1929, that I last saw h[illegible] alive on Jan 16, 1929, and that death occurred, on the date stated above, at 7p.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C A Larsen M. D.

1/17, 1929 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho	1/17/29

20. Undertaker A B Eckersell

Address Rigby

RECEIVED FEB 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 65002

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Jefferson.

City of Rigby.

Registration District No. 98

Primary Registration District No. 2176

(No. .....)

Local Registrar's No. 7

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Douglas Ray Kunz.

(a) Residence. No. Main St. St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Babe.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. 7, 1928

7 AGE: Years 0 | Months 1 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Babe.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rigby, Idaho.

PARENTS

10 NAME OF FATHER: George Kunz.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bern, Idaho.

12 MAIDEN NAME OF MOTHER: Edity Bills.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Rigby, Idaho.

14 Informant George Kunz

(Address) Rigby, Idaho.

15 Filed 2-1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January (Month) 30 (Day) 1929 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1/29/29, 19....., to 1/30, 1929, that I last saw him alive on 1/29/29, 19....., and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

1-30, 1929 (Address) Rigby

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Montpelier, Idaho.

Date of Burial: 2/1/29 19

20. Undertaker: [signature] Address: Rigby.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65003

PLACE OF DEATH
County of Jefferson
City of Ririe

Registration District No. 98
Primary Registration District No. 2176
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Mrs Jennie R J McGuire
(a) Residence. No. Ririe Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widow
6. DATE OF BIRTH (month, day and year) Dont Know
7. AGE Years 62 Months Days If LESS than 1 day ..... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Druggist
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER Pearson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Lucile McGuire
(Address) Idaho Falls Ida

15. Filed 2-1, 1929 C H Gavin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1929, to Jan 22, 1929
that I last saw her alive on Jan 22, 1929
and that death occurred, on the date stated above, at 3.30 a m.
The CAUSE OF DEATH* was as follows:
Acute Rheumatism of the heart
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Sam F Price M. D.
....., 19.... (Address) Ririe Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls
Date of Burial Jan 27 1928

20. Undertaker Cliff Hayes
Address Idaho Falls

FEB 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65004

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Jefferson. Registration District No. 98
City of Menan Primary Registration District No. 2176
(No.)
Local Registrar's No. 9
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Edward Gunderson.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or WIFE of) Mary M. Gunderson.

6 DATE OF BIRTH (month, day and year) Nov. 5 1852

7 AGE	Years	Months	Days	If LESS than 1 day, or hrs. min.
	76	3	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS
10 NAME OF FATHER Thomas Gunderson.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway
12 MAIDEN NAME OF MOTHER Olena Hanson.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant E C Gunderson
(Address) Menan, Idaho.

15 Filed 2-1, 1929 C A Irwin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. (Month) 10, (Day) 1929, (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb., 1928, to June, 1928, that I last saw h.. alive on Feb 9, 1929, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:
Chr. Myocarditis & Arteriosclerosis
(duration) 9 yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. R. Neat M. D.
2/11, 1929 (Address) Rigby, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Annis, Idaho. Date of Burial: 2/13/29 19

20. Undertaker A B Eckersell Address: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65005
Local Registrar's No. 10

PLACE OF DEATH
County of Jefferson
City of Rigby
Registration District No. 98
Primary Registration District No. 2176
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ellen (Powell) Adams.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Married

5a If married, widowed, or divorced
(or) WIFE of Alma Dorus Adams.

6 DATE OF BIRTH (month, day and year) Jan. 3, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	0	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10 NAME OF FATHER Joseph Powell.
11 BIRTHPLACE OF FATHER (city or town) (State or country) England.
12 MAIDEN NAME OF MOTHER Thurza Powell.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant A. D. Adams.
(Address) Rigby, Idaho R. #2

15 Filed 2-1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 24th 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1920, to Jan 24th, 1929, that I last saw h[illegible] alive on Sept 25th, 1928, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:
Arthritis Deformans
Arterio Sclerosis
(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Rigby Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical examinations
(Signed) H. P. Anderson, M. D.
Jan 26th, 1929 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Salt Lake City, Utah	1/27/29 19

20. Undertaker [signature] Address Rigby.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65006

Local Registrar's No. 11

Registration District No. 98
Primary Registration District No. 2176
(No.)

PLACE OF DEATH

County of Jefferson
City of Menan.
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Brigham G. Lawson.

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of ~~XX (or) XXXXX~~ Susanna Poole Lawson.

6 DATE OF BIRTH (month, day and year) Jan. 20, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	0	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ogden, Utah.

PARENTS
10 NAME OF FATHER Joseph Lawson.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Isle of Man.
12 MAIDEN NAME OF MOTHER Ruth Greenway.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales.

14 Informant Susanna Poole Lawson.
(Address) Menan, Idaho.

15 Filed 2-1, 1929 C. A. Larson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. (Month) 23. (Day) 1929. (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1929, to Jan. 23, 1929, that I last saw him alive on Jan. 22, 1929, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. R. West, M. D.
Jan. 28, 1929 (Address) Rigby, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Annis, Idaho.	1/26/29 19

20. Undertaker A B Eckersell — Address Rigby.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65007

Registration District No. 23

Primary Registration District No. 2017

Local Registrar's No.

PLACE OF DEATH

County of Jerome

City of Hazelton

(No. At Home)

(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Ella Bond Freeman

(a) Residence. No. Hazelton R.F.D. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: H. O. Freeman

6. DATE OF BIRTH (month, day and year): Aug 6 1873

7. AGE — Years: 65 | Months: 7 | Days: 13 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Cleveland Ohio

PARENTS

10. NAME OF FATHER: Elias Bond

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Fannie Bond

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: H. O. Freeman

(Address) Hazelton R F D

15. Filed Mar 1, 1929 L. Hopper Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1929 19 to Feb. 19, 1929 19 that I last saw her alive on Feb. 19, 1929. 19 and that death occurred, on the date stated above, at 10:35A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Unknown mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Reflexis

(Signed) L. Hopper, M. D.

Feb. 25, 1929 (Address) Hazelton, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Mar 2, 1929

20. Undertaker: T. J. Grossman — Address: Twin Falls

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65008

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 105
Local Registrar's No. 25
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gilbert - Carey
(a) Residence. No. 1124 - Lakeside St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widower

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lucy J. Brotherton - Carey

6. DATE OF BIRTH (month, day and year) 1837 - 2 - 7

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
91	11	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Quebec,

PARENTS

10. NAME OF FATHER Lawrence Carey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Quebec
12. MAIDEN NAME OF MOTHER Odett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Quebec

14. Informant Mrs Annie E. Delyea
(Address)

15. Filed 2/6/29, 1929 D.D. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 2, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Feb. 2, 1929
that I last saw him alive on Jan 12, 1929
and that death occurred, on the date stated above, at 11 a.m.,
The CAUSE OF DEATH* was as follows:
Strangulated inguinal hernia
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis
(Signed) John A. Wood, M. D.
Feb 3, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Thomas Cem. CD'Alene — Date of Burial: 2-4-1929

20. Undertaker: Cassedy Funeral Home — Address: CD'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65009

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1057
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

2. FULL NAME Virginia Love.
(a) Residence. No. 1224 - 3rd St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Harry Love
6. DATE OF BIRTH (month, day and year) 1878 - Nov. 12
7. AGE Years 50 Months 2 Days 21 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Texas.

PARENTS
10. NAME OF FATHER Silas W. Rhodes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland.
12. MAIDEN NAME OF MOTHER Lulu Hogard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ark.

14. Informant Harry Love
(Address)

15. Filed 2/6, 1929 D. Drennen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November, 1928, to Feb 2, 1929
that I last saw her alive on Feb 2, 1929
and that death occurred, on the date stated above, at 1:10 a. m.
The CAUSE OF DEATH* was as follows:
Carcinosis - generalized
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Colorado
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Tissue examination.
(Signed) Alexander Barclay, M. D.
2-5-29, 19 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene
Date of Burial 2-6 1929
20. Undertaker Cassedy Funeral Home
Address C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65010

Local Registrar's No. 27

PLACE OF DEATH

County of Kootenai

City of Ramsey

Registration District No.

Primary Registration District No. 1057

(No. Ramsey, Idaho.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank O. Hansell

(a) Residence. No. Ramsey, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Emma Hansell

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	6	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ry. Telegrapher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Northern Pacific

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Robert Hansell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Hannah White

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Emma Hansell

(Address) Ramsey, Idaho.

15. Filed Feb 5, 1929 [illegible] Registrar

N. B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 29 29
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jany 29, 1929, to Jany 29, 1929
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 5.30 p. m.
The CAUSE OF DEATH* was as follows: Stroke of cerebral apoplexy. I was called when first stricken, but he had died shortly before I could get to him.
(duration) yrs. mos. 2 hours. ds.

CONTRIBUTORY (Secondary) General Arterio-Sclerosis
Atheroma / (duration) about 2 or 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Frank Wenz, M. D.
1/31. 19 29 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Incineration	Feb. 2 1929
20. Undertaker: Smith & Co	Address: Spokane, Wash.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65011

Registration District No. 3
Primary Registration District No. 1051
Local Registrar's No. 28

PLACE OF DEATH
County of Kootenai
City of Rathdrum (No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Harvey Justice

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Ann Justice

6. DATE OF BIRTH (month, day and year) Feb. 28 1839

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
89	10	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS
10. NAME OF FATHER Jackson Justice
11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia
12. MAIDEN NAME OF MOTHER J Hall.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) West Virginia

14. Informant J. P. Justice
(Address) Corbin, Idaho

15. Filed Feb 7, 1929 D. D. Brennan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 3. 1929, to Jany 17. 1929.
That I last saw him alive on Jan. 16. 1929.
and that death occurred, on the date stated above, at 6 15 m.

The CAUSE OF DEATH* was as follows: Acute Bronchs - Pneumonia

(duration) ... yrs. ... mos. 17 ds.
CONTRIBUTORY (Secondary) Epidemic Influenza and Colitis
(duration) ... yrs. ... mos. 20 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Frank Wm. M. D.
1/28, 1929 (Address) Rathdrum Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Grove Cemetery	Jan. 19th 1929

20. Undertaker	Address
Cassedy Funeral Home	Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65013

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1051
Local Registrar's No. 30
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Howard Rudolph Hattenburg
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) May 11 1908
7. AGE Years 20 Months 7 Days 18 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Working in woods
(c) Name of employer Panhandle Lumber Co.
9. BIRTHPLACE (city or town) (State or country) Marion N. Dakota

PARENTS
10. NAME OF FATHER Lantie Hattenburg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minnesota
12. MAIDEN NAME OF MOTHER Ethel Best
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minnesota

14. Informant Mrs. Ethel Hattenburg
(Address) Rathdrum Idaho

15. Filed Feb 7, 1929 D. D. Drennan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from on January 28, 1929
that I last saw in alive on Jan 28, 1929
and that death occurred, on the date stated above, at 5:15 P m.
The CAUSE OF DEATH* was as follows:
accidental rifle wound
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Hemorrhage
Shock (duration) 5 hrs yrs. mos. ds.

18. Where was disease contracted if not at place of death? in woods
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Bullet wound in head & shoulder
(Signed) Nelson Heuser M. D.
Feb 1, 1929 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pine Grove Cemetery - Rathdrum
Date of Burial: 2/2 1929
20. Undertaker: Cassedy Funeral Home
Address: Rathdrum

F. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65014

PLACE OF DEATH

County of Kootenai

City of Rathdrum

Registration District No. 30

Primary Registration District No. 1051

Local Registrar's No. 21

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary H. Dietrich

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of M. T. Dietrich

6. DATE OF BIRTH (month, day and year) September 7

7. AGE Years 59 Months 4 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS

10. NAME OF FATHER Adolph Engel

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Elizabeth Frank

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant M. T. Dietrich
(Address) Rathdrum Idaho

15. Filed Feb 7, 1929 D. D. Drennan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 4. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5., 1928, to Jany 4., 1929
that I last saw her alive on " 4., 1929
and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Stroke of Apoplexy)
..... (duration) ..... yrs. ..... mos. 1/2 hr.

CONTRIBUTORY (Secondary) General Arteriosclerosis (duration) 2 or 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Frank Wenz, M. D.

1/5, 1929. (Address) Rathdrum Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Coeur d'Alene-Forest Cemetery — Date of Burial: 1/7 1929

20. Undertaker: Cassedy Funeral Home — Address: Rathdrum

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED MAR 9 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 65015
Registered No. 22

1. PLACE OF DEATH
County of Kootenai
Registration District No. 30
Primary Registration District No. 1037
City of Post Falls (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: October (Month) 16 (Day) 1845 (Year)

7. AGE: 83 Yrs. 3 Mos. 24 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Benjamin Young

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: unobtainable

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Eric Johnson
(Address): Post Falls, Ida.

15. Filed 2/12 1929 D. D. Brennan Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 10th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1928 to Feb 10 1929 that I last saw him alive on Feb 10th 1929 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) ... Yrs. 1 mos. ... ds.

Contributory (Secondary) ...

(Duration) ... Yrs. ... mos. ... ds.

(Signed) T. L. McCauley M. D.
Feb 10. 1929 (Address) Post Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: East Falls Idaho — DATE OF BURIAL: Feb 1929

20. UNDERTAKER: Nash Yeager & Calloway — ADDRESS: Spokane

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65016

PLACE OF DEATH
County of Kootenai
City of
Registration District No. 30
Primary Registration District No. 1051
Local Registrar's No. 33
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samual Beaver

(a) Residence. ~~No.~~ Hayden Lake ~~St.~~
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Jessie Beaver

6. DATE OF BIRTH (month, day and year) Jan. 8, 1865

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	I	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER James Beaver
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Mary Hogue
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Mrs. Jessie Beaver
(Address)

15. Filed 2/12, 1929 O. O. Arnemann, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 8. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4., 1928, to Feby 8., 1929
that I last saw h— alive on January 25, 1929
and that death occurred, on the date stated above, at 11.00 P m.
The CAUSE OF DEATH* was as follows: Chronic Pyelo-Nephritis
(duration) 1 to 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Cystitis about 2 to 3
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date ~~April~~ Dec of 28
Was there an autopsy? No Spokane, Wash
What test confirmed diagnosis?
(Signed) Frank Wells, M. D.
2/9., 1929 (Address) Rathdrum, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	2-11 1929

20. Undertaker P B Mooney Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Wood

RECEIVED MAR 9 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65017

County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1051
Local Registrar's No. 34
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Helen G. Smith

(a) Residence. No. 715 So 12th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Jan 28, 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	0	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho

PARENTS

10. NAME OF FATHER W. E. Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn.
12. MAIDEN NAME OF MOTHER Jane Caryl
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn.

14. Informant W. E. Smith.
(Address) Coeur d'Alene

15. Filed 2/12, 1929 D. D. Drennan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1929 to Feb. 11, 1929
that I last saw her alive on Feb 9th, 1929
and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:
Influenza.
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Premature birth
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John Waggoner, M. D.
Feb. 11, 1929 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	2/13 1929

20. Undertaker P. B. Mooney Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Dwyer

RECEIVED MAR 9 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

(No. Home Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65018

Local Registrar's No. 30

2. FULL NAME Amos Sirty

(a) Residence. No. 1028 Hastings Ave St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nora Sirty

6. DATE OF BIRTH (month, day and year) June 19, 1858

7. AGE	Years	Months	Days	If LESS than 1 day,
	70			hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Fredrick Sirty

11. BIRTHPLACE OF FATHER (city or town) (State or Country) France

12. MAIDEN NAME OF MOTHER Susan Sirty

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) France

14. Informant Mrs Nora Sirty

(Address) Coeur d'Alene Ida

15. Filed 2/13, 1929 A D. Drennan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9, 1929, to Feb 11, 1929

that I last saw him alive on Feb. 11, 1929

and that death occurred, on the date stated above, at 1130 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J C Meyer, M.D.

Feb. 13, 1929 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverside Park Cem	2-13 1929

20. Undertaker	Address
R B Mooney	Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65020

PLACE OF DEATH
County of Kootenai
City of Coeurd Alene

Registration District No. 30
Primary Registration District No. 1051
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 37

2. FULL NAME Ida Margret Hanson
(a) Residence. No. 216 - Garden St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1909 - 10 - 18

7. AGE Years 19 Months 3 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER Fred Hanson
11. BIRTHPLACE OF FATHER (city or town) Denmark
(State or Country)
12. MAIDEN NAME OF MOTHER Nellie Freeman
13. BIRTHPLACE OF MOTHER (city or town) Iowa
(State or Country)

14. Informant [illegible]
(Address) [illegible]

15. Filed 2/14, 1929 D. D. Drennan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12, 1929, to Feb 13, 1929
that I last saw her alive on Feb 12, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Valvular Endocarditis (Mitral)
..... (duration) Not Known yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam.
(Signed) J. O. Dwyer, M. D.
Feb 14, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cem, C D Alene
Date of Burial: 2-14 1929

20. Undertaker: Cassedy Funeral Home
Address: C D Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 9 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65021

Local Registrar's No. 38

2. FULL NAME Helen Estella Nichols

(a) Residence. No. 318 Eight St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 8 - 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	1	6	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d Alene
(State or country) Idaho

PARENTS

10. NAME OF FATHER H. L. Nichols

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Oregon

12. MAIDEN NAME OF MOTHER Elma Schmelzer

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Oregon

14. Informant H. L. Nichols

(Address) Coeur d Alene Idaho

15. Filed 2/15, 1929 D. D. Drennan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1929, to Feb 14, 1929

that I last saw her alive on Feb 14, 1929

and that death occurred, on the date stated above, at 1300 m.

The CAUSE OF DEATH* was as follows:

Erysipelas.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. C. Mayer, M. D.

2/15, 1929 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	2-15 1929
20. Undertaker	Address
R. D. Mooney	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65022

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1051
Local Registrar's No. 39
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Adell Hazelton.

(a) Residence. No. 508 Davidson St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced
~~HUSBAND~~ (or) WIFE of Royal D. Hazelton

6. DATE OF BIRTH (month, day and year) 5-7-

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Thomas Stitt

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Vanderhoff

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant L. A. Hazelton
(Address)

15. Filed Feb 16, 1929 D. R. Drennon Registrar
F.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 14, 1929, to February 14, 1929
that I last saw h sr alive on February 14, 1929
and that death occurred, on the date stated above, at 5 40 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Cholecystitis, Chronic

(duration) one yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? Do not know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Harold T. Anderson M. D.
February 15, 1929 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C D'Alene	2-16 1929
20. Undertaker	Address
Cassedy Funeral Home	C D'Alene

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65023

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 10 S-1
Local Registrar's No. 40
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Perremoud

(a) Residence. No. 829 - 6th St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chas.

6. DATE OF BIRTH (month, day and year) 1840 - 5 - 5

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	9	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Horse wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10. NAME OF FATHER Jonas Vautravers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Celestine
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Armand Perremoud
(Address)

15. Filed 2/20, 1929 D. D. Drennan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows:

Senile Decay
no Doctor.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) D D Drennan, M. D.
2/19, 1929 (Address) Local Registrar Coeur d'Alene,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C D'Alene	2-20 1929
20. Undertaker	Address
Cassady Funeral Home	C D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65024

Local Registrar's No. 41

2. FULL NAME Henry C. Shaver

(a) Residence. No. 312 1/2 Fourth St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emilie Shaver

6. DATE OF BIRTH (month, day and year) Aug 8, 1853

7. AGE: Years 76, Months 6, Days 10. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Newspaper owner

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Ill.

PARENTS

10. NAME OF FATHER: Hyram Shaver

11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Mrs Emilie Shaver
(Address) Coeur d'Alene Ida

15. Filed 2/20, 1929 D. D. Drennan, F.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November, 1927, to Feb. 18, 1929

that I last saw him alive on November, 1927

and that death occurred, on the date stated above, at 4 P m

The CAUSE OF DEATH* was as follows:

Cerebral softening.

..... (duration) 2 yrs. ..... mos. ..... ds

CONTRIBUTORY (Secondary) Cerebral hemorrhage

..... (duration) 2 yrs. ..... mos. ..... ds

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) John Elwood, M. D.

Feb. 20, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery

Date of Burial: 2/20 1929

20. Undertaker: R B Mooney

Address: Coeur d'Alene Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65025

Local Registrar's No. 42

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1051

(No. ....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John E. Murphy

(a) Residence. No. 1305 Government Way St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Katherine Murphy

6. DATE OF BIRTH (month, day and year) June 6 1858

7. AGE	Years	Months	Days	If LESS than 1 day,
	70	8	15	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER William Murphy

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Emma Blair

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs J. E. Murphy

(Address) Coeur d'Alene

15. Filed 2/25, 1929 D. D. Drennan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov, 1928, to Feb 21, 1929

that I last saw him alive on Feb. 20, 1929

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism. Cerebral Softening

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J C Myers M. D.

Feb 21, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Thomas Cem	2-23 1929
20. Undertaker	Address
R B Mooney	Box 9

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65026

PLACE OF DEATH
County of Kootenai
City of Post Falls

Registration District No. 30
Primary Registration District No. 1051
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 43

2. FULL NAME Grace Ethel Bryant

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: J. E. Bryant

6. DATE OF BIRTH (month, day and year): 20 May 1888

7. AGE: HD Years: 4 Months: 9 Days: If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Wis.

PARENTS

10. NAME OF FATHER: Johial Berry
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Florence Taylor ~~Grace Ethel Berry~~
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N. Y.

14. Informant: Ethel Very Graham
(Address): 2910 E. Boone Spokane Wn

15. Filed 2/25, 1929 D. D. Drennan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19th, 1929, to Febr 24, 1929
that I last saw her alive on Febr 23rd, 1929
and that death occurred, on the date stated above, at 1300 m.
The CAUSE OF DEATH* was as follows:
Cerebro-spinal Meningitis
..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Symptoms +
(Signed) F. L. McCauley, M. D.
Feb 25, 1929 (Address) Post Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cem. CD Alene
Date of Burial: 2-26 1929

20. Undertaker: Cassedy Funeral Home
Address: CD Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65027

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1051
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 44

2. FULL NAME Annie McGuire
(a) Residence. No. ..... St. Rathdrum, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of F. P. McGuire

6. DATE OF BIRTH (month, day and year) May 14-1849

7. AGE Years 79 Months 9 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) County Carvan
(State or country) Ireland

PARENTS
10. NAME OF FATHER Thomas Morris
11. BIRTHPLACE OF FATHER (city or town) Ireland
(State or Country)
12. MAIDEN NAME OF MOTHER Rose Riley
13. BIRTHPLACE OF MOTHER (city or town) Ireland
(State or Country)

14. Informant Thomas McGuire
(Address) Rathdrum Idaho

15. Filed 2/26, 1929 D. D. Drennan Registrar
H. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Decbr. 13, 1928, to Febry. 16, 1929
that I last saw her alive on Febry 16, 1929
and that death occurred, on the date stated above, at 9.45 a m.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia
..... (duration) ..... yrs. 2 mos. 3 ds.
CONTRIBUTORY (Secondary) Epidemic Influenza
..... (duration) ..... yrs. 2 mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Frank Wenz M. D.
2/15, 1929 (Address) Rathdrum Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. Thomas Cemetery - C D'Alene
Date of Burial 2/19 1929

20. Undertaker Cassedy Funeral Home
Address Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65028

PLACE OF DEATH
County of Kootenai
City of Dalton Gardens

Registration District No. 30
Primary Registration District No. 1051
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 45

2. FULL NAME John Merkel Sr
(a) Residence. No. Dalton Gardens St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Dora Merkel

6. DATE OF BIRTH (month, day and year): July 9 1858

7. AGE: Years 70 | Months 7 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Russia

PARENTS
10. NAME OF FATHER: Christian Merkel
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Margaret Procht
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14. Informant: Ed Merkel
(Address) Coeur d Alene, Ida.

15. Filed 3/6, 1929 D D Drennan Registrar
Ed.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1927, to Mar., 1929
that I last saw him alive on Jan 15, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Chr. Myocarditis
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Harold J. Sturgis, M. D.
3-5, 1929 (Address) Coeur d Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Dalton Gardens | Date of Burial: 3/ 1929

20. Undertaker: None R B Mooney | Address: P & A

RECEIVED MAR 8 1929

Form V. S. No. 5. 10M. 6-26-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 65029
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Kendrick
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Carrie Hooker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: Aug (Month) 2 (Day) 1853 (Year)

7. AGE: 75 yrs. 7 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Ole Vagnild

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Johanna Nelson
(Address) R 7 D 11 Kendrick Ida.

15. Filed Feb 25 1929 B. F. Nesbit Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 22, 1929 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1929 191 , to Feb. 22, 1929 191 that I last saw her alive on Feb. 14, 1929 191 , and that death occurred on the date stated above, at 5:30AM M.

The CAUSE OF DEATH* was as follows:
Chronic myocarditis

(Duration) 5 yrs. mos. ds.

Contributory (Secondary): Senility
(Duration) yrs. mos. ds.

(Signed) Oliver J. Morehead M. D.
2-25- 1929 (Address) Kendrick, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Big Bear Ridge — DATE OF BURIAL: Feb. 25 1929

20. UNDERTAKER: R. M. Grim — ADDRESS: Moscow Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED MAR 13 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 62

County of Latah — Primary Registration District No. 2442

City of Near Genesee (No. ....., ... St.)

File No. 65030

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Louie Michelsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Married

6. DATE OF BIRTH: July 14 1871
(Month) (Day) (Year)

7. AGE: 57 yrs. 6 mos. 21 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Christian Michelsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Louie Michelsen
(Address) Genesee Idaho

15. Filed 2/6 1929 W. N. Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 5, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1928, to Feb 5 1929, that I last saw h[illegible] alive on Jan 10 1929, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Urinary Carcinoma of bowel.

(Duration) 2 yrs. [illegible] mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Armstrong M. D.
2/6 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Genesee Valley Cemetery
DATE OF BURIAL: 2/8 1929

20. UNDERTAKER: F. R. Hoot
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

RECEIVED MAR 7 1929

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 65031

Registered No. 8

1. PLACE OF DEATH.

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME EDNA ALVENA ELIZABETH LUNDQUIST

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: April (Month) 27 (Day) 1909 (Year)

7. AGE: 19 yrs. 9 mos. 16 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION

(a) Trade, professsion, or particular kind of work: House wife

(b) General nature of industry business, or establishment in which employed (or employer): ✓

9. BIRTHPLACE (State or Country): Hailey Ida.

10. NAME OF FATHER: Harvey C. Schwand

11. BIRTHPLACE OF FATHER (State or Country): Calif.

12. MAIDEN NAME OF MOTHER: Mary C. Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. V. Lundquist

(Address) Moscow Ida.

15. Filed Mch 1 1929 W H Carothers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 18th (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 15th 1928, to Feb. 12- 1929, that I last saw h[illegible] alive on Feb. 12- 1929, and that death occurred on the date stated above, at 6 15 P.M.

The CAUSE OF DEATH* was as follows:

Pernicious anemia following Child birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W H Carothers M. D.

2-14- 1929 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, ~~Transients or~~ Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was Disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Hailey Ida.

DATE OF BURIAL: 2/17 1929

20. UNDERTAKER: T. R. Short

ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

RECEIVED MAR 7 1929

Form V. S. No. 5. 10M. 6-20-H.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 65032
Registered No. 4

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Shirley LaVerl Christensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Child

6. DATE OF BIRTH: Nov/ 10 1928 (Month) (Day) (Year)

7. AGE: ..... yrs. 3 mos. ..... ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Moscow, Idaho

10. NAME OF FATHER: Nels M. Christensen

11. BIRTHPLACE OF FATHER (State or Country): Min.

12. MAIDEN NAME OF MOTHER: Hattie Poole

13. BIRTHPLACE OF MOTHER (State or Country): Kan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N.M. Christensen
(Address) Moscow, Idaho

15. Filed Mch 1 1929 W.H. Gavithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 10, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 9:30 A. M.
The CAUSE OF DEATH* was as follows:
Pneumonia of left lung.
Autopsy to determine cause of death
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H.R. Short Coroner M. D.
2/12 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 2/12/29 191

20. UNDERTAKER: H. R. Short
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 2. 10M. 6-20-11. RECEIVED MAR 7 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 65033
Registered No. 9
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Margaret Constance Luvaas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (*Write* the word.)

6. DATE OF BIRTH: Jan. 19 1912 (Month) (Day) (Year)

7. AGE: 17 yrs. ..... mos. 25 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work ... School girl
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Moscow, Idaho

10. NAME OF FATHER: Bert P. Luvaas

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Martha Dahl

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B.P. Luvaas
(Address) Moscow, Idaho

15. Filed Mch 1 1929 W. H. Carothers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: FeB. 14, 1929 191 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 29 1929, to Feb. 14 1929 that I last saw her alive on Feb. 14 1929, and that death occurred on the date stated above, at 3:45 P. M.

The CAUSE OF DEATH* was as follows:
Pericarditis with effusion

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) acute Cholecystitis & Rheumatic fever

(Duration) ..... yrs. ..... mos. 18 ds.

(Signed) J. Harry Einhouse M. D.
2/16 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 2/16/29 191

20. UNDERTAKER: H. R. Short
ADDRESS: Moscow

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11. RECEIVED MAR 7 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., Leo St.)

File No. 65034
Registered No. 10
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Robert Goetz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH: Feb. 19 (Month) (Day) 1929 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Child
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Moscow, Idaho

10. NAME OF FATHER: Fred ##### Goetz

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Selma Ronholt

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Goetz
(Address) ## Viola, Idaho

15. Filed Mch 1 1929 W. H. Carthers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 21 (Month) 1929 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19 1929, to Feb. 21 1929 that I last saw him alive on Feb. 21 1929, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Hard labor gains

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
2/22 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Viola, Idaho
DATE OF BURIAL: 2-22 1929

20. UNDERTAKER: F. R. Short
ADDRESS: Moscow

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-A—25—M. 1-19

RECEIVED MAR 2 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65

Primary Registration District No. 2145

File No. 65035

Registered No.

1. PLACE OF DEATH

County of Latah

City of Potlatch (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hiram W Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 25 (Day) 1863 (Year)

7. AGE: 65 Yrs. 4 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber Mill.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: T. W. Carter

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: E Short

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas W Carter
(Address) Potlatch Ida.

15. Filed Feb 12 1929

J. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1929, to Feb 11th 1929, that I last saw him alive on Feb 11th 1929, and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary): Arterio-sclerosis

(Duration) 10 yrs. mos. ds.

(Signed) J. W. Thompson M. D.

2/12/1929 (Address) Potlatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Potlatch Ida

DATE OF BURIAL: Feb 17 1929

20. UNDERTAKER: Adrian Palouse Wash.

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED MAR 2 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Potlatch

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65

Primary Registration District No. 2145

(No. ..... St.)

File No. 65036

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Manley Whitney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Feb (Month) 25 (Day) 1961 (Year)

7. AGE: 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Mina

10. NAME OF FATHER: H Whitney

11. BIRTHPLACE OF FATHER (State or Country): Main

12. MAIDEN NAME OF MOTHER: Melisa Carson

13. BIRTHPLACE OF MOTHER (State or Country): Main

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Trotter

(Address) Potlatch

15. Filed Feb 20th 1929 Dr. Jr. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17th 1929, to Feb. 19th 1929 that I last saw him alive on Feb 19th 19.., and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows: Chronic parenchymatous Nephritis

..... (Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Broncho-pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.

(Signed) Jr. Thompson M. D.

2/20/1929 (Address) Potlatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Freeze Cem

DATE OF BURIAL: Feb 22 1929

20. UNDERTAKER: C. M. Irwin

ADDRESS: Palouse Wash.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED MAR 2 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Potlatch

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65

Primary Registration District No. 2145

(No. ..... St.)

File No. 65037

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lloyd W. Metcalf.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 18 (Day) 1900 (Year)

7. AGE: 28 Yrs. 5 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer): Potlatch Lumber Co.

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: M Metcalf

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Jessie Reynolds.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Metcalf

(Address) Potlatch Ida

15. Filed Feb. 7th 1929

Dr J. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 27 1929, to Feb. 5th 1929 that I last saw him alive on Feb 4th 1929, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary): Acute parenchymatous nephritis

..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Dr J. C. Gibson. M. D.

2/5/ 1929. (Address) Potlatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash. DATE OF BURIAL: Feb 7 1929

20. UNDERTAKER: [illegible] Lewis ADDRESS: Palouse Wash.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65040

PLACE OF DEATH RECEIVED FEB 20 1929

County of Lemhi
City of Leadore

Registration District No. 41
Primary Registration District No. 2116
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Mrs Julia McDonough Keating
(a) Residence. No. Leadore Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Keating

6. DATE OF BIRTH (month, day and year) Dec 4th 1870

7. AGE: 58 Years | Months: 1 | Days: 10 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hotel Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS
10. NAME OF FATHER Patrick McDonough
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Julia Lydon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant William Keating
(Address) Leadore, Idaho

15. Filed 1/10, 1929 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 14th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1929, to Jan 14, 1929
that I last saw her alive on Jan 14, 1929
and that death occurred, on the date stated above, at 5-45 P m.
The CAUSE OF DEATH* was as follows:
Hemmorrhage from gastric ulcer
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) Bratton, M.D.
1/14, 1929 (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg Minn | Date of Burial 19

20. Undertaker: Jm C Doebler | Address: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65041

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. ....

2. FULL NAME IDA MINERT

(a) Residence. No. Salmon Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Eli Minert

6. DATE OF BIRTH (month, day and year) April 10, 1854

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	9		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tioga County, New York

PARENTS

10. NAME OF FATHER Edwin T. Andrews
11. BIRTHPLACE OF FATHER (city or town) (State or Country) State of New York
12. MAIDEN NAME OF MOTHER Sarah Young
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Strausburg, Germany

14. Informant Inez M. Merritt (Daughter)
(Address) Salmon, Idaho

15. Filed 7/10 1929 Clio Bellomy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Jany 9th (Day) (Year) 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1928, to Jany 9, 1929
that I last saw her alive on Jany 9, 1929
and that death occurred, on the date stated above, at 4 (P) m.
The CAUSE OF DEATH* was as follows:

Hemorrage from bowels

(duration) yrs. 10 mos. ds.
CONTRIBUTORY (Secondary) Probably Cancer of Stomach
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Dr Wright, M. D.
7/11, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	1-13" 1929
20. Undertaker	Address
W M C Dockle	Salmon Ida.

RECEIVED FEB 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65042

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Mrs Mary E. Clark
(a) Residence. No. Salmon Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 3rd 1845

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
83	1	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois Texas

PARENTS

10. NAME OF FATHER Gearian
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant Wm C Daehler
(Address) Salmon Ida

15. Filed 7/10, 1929, Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January-11th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1927, to Jan 10, 1929
that I last saw her alive on Jan 10, 1929
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis - Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia
..... (duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) J. Stratton, M. D.
Jan 11, 1929 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery
Date of Burial: 1-14th 1929

20. Undertaker: Wm C Daehler
Address: Salmon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65043

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 5
Primary Registration District No. 2129.
(No.)
Local Registrar's No. 3

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Amelia Fields.

(a) Residence. No. Winchester Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of William Ernest Fields

6. DATE OF BIRTH (month, day and year) Feb 15 1881

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	11	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Frederick Schmidt. Frederick Schmidt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Alsace-Lorraine Germany

14. Informant W. E. Fields
(Address) Winchester Ida.

15. Filed 2/15 1929. P. E. Dellert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 28 1929 to Feb 8 1929
that I last saw h[illegible] alive on Feb 8 1929
and that death occurred, on the date stated above, at 8 35 P m.

The CAUSE OF DEATH* was as follows:
Uremic Coma. Bronchopneumonia.
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Cirhosis - Sclerosis Cardio-Cerebellar
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) John F Yost, M. D.
Feb 6. 1929 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F. Cemetery Lewiston Ida	2/7/29 19

20. Undertaker Clyde Clark Lewiston Ida

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65045

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 50
Primary Registration District No. 2129
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

2. FULL NAME Roy Estes
(a) Residence. No. Winchester Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) not known
7. AGE 50 Years Months Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lath Mill employee
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Cuny Mt. Lumber Co.
9. BIRTHPLACE (city or town) (State or country) Not known

PARENTS
10. NAME OF FATHER A. J. Estes - Seattle Wash
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant John F. Gist M.D.
(Address) Winchester Idaho

15. Filed 7/28, 1929 R. E. Dunlap Registrar

MEDICAL CERTIFICATE OF DEATH

66

16. DATE OF DEATH February - 25 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1929, to Feb 25, 1929
that I last saw him alive on Feb 25, 1929
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Alcoholism.
Had been drinking denatured alcohol.
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John F. Gist, M. D.
2/27 1929 (Address) Winchester Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Seattle Wash Cincinnati Idaho
Date of Burial Feb 4 1929
20. Undertaker Clyde Clevis Cincinnati Idaho
Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Public Health Adviser
Food and Drug Inspection
Bacteriological Laboratory
Chemical Laboratory
Sanitary Engineer
Bureau of Child Hygiene
Vital Statistics

DAVID BURRELL, Commissioner

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
Lava Hot Springs, Lava
Idaho Soldiers' Home, Boise
Northern Idaho Sanitarium, Orofino
State School & Colony, Nampa

H. C. BALDRIDGE, Governor

March 19, 1929.

Dr. John F. Gist,

Winchester, Idaho.

Re: 65045.

Dear Doctor:

We are in receipt of the death certificate of Roy Estes who died at Winchester February 25, 1929. As no age is given and if you do not know his exact age, would you kindly give us his approximate age. This for statistical purposes.

Thanking you in advance for the courtesy of a prompt reply, I am

Respectfully yours,

C. K. Macey

Stamped env. enc.

C. K. Macey,
State Registrar.

In reply to the Alumni, Roy Estes must have been near 50 yrs. of age.

Yours

J. F. Gist

RECEIVED MAR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65046

PLACE OF DEATH

County of Lincoln
City of Shoshone

CERTIFICATE OF DEATH

Registration District No. 1616
Primary Registration District No.
(No. McMahon Apts.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 4

2. FULL NAME Charlotte Calhoun

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David C Calhoun

6 DATE OF BIRTH (month, day and year): Sept 19 1853

7 AGE: Years 75 | Months 5 | Days 17 | If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Terre Haute Ind.

PARENTS
10 NAME OF FATHER: Jas. Wilson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: Nancy Perkins Wilson
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Frank Silvers
(Address)

15 Filed Mch 6, 1929 J L [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 6 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 5, 1929, to Mar 5, 1929, that I last saw her alive on Mar 5, 1929, and that death occurred, on the date stated above, at 4:00 m.

The CAUSE OF DEATH* was as follows: Chronic Arthritis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phy Exam
(Signed) F. E. Harriff, M. D.
Mar 6, 1929 (Address) Shoshone

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Bellevue Idaho
Date of Burial: 19

20. Undertaker: C E Hickok
Address: Shoshone Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 12 1929

STATE OF IDAHO 65047
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 3

PLACE OF DEATH

County of Lincoln
City of Shoshone

CERTIFICATE OF DEATH

Registration District No.
Primary Registration District No.
(No. Home)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 34.

2. FULL NAME Wesley Joseph Otto

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feby 12, 1926

7 AGE: Years 3 | Months | Days 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Shoshone Ida

PARENTS
10 NAME OF FATHER A H Otto
11 BIRTHPLACE OF FATHER (city or town) (State or country) Myrtle Point, Ore.
12 MAIDEN NAME OF MOTHER Elizabeth Springer
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant A H Otto
(Address)

15 Filed Mch 4th, 1929 J L Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 3 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1929, to Mar 3, 1929
that I last saw h alive on Mar 3, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Double Lobar Pneumonia
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phy Exam
(Signed) F. E. Barrett, M. D.
3/4, 1929 (Address) Shoshone

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Shoshone
Date of Burial: Mch 4 1929

20. Undertaker: C E Hickok
Address: Shoshone

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 65048

Local Registrar's No. ~~33~~ 2

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Lincoln

City of Shoshone

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ed Garner

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie Garner

6 DATE OF BIRTH (month, day and year): 28 Feb 1859

7 AGE: Years 69 | Months 11 | Days 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ogensburg N Y

PARENTS

10 NAME OF FATHER: Thomas Garner

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Joe Garner

(Address)

15 Filed Mch 1st, 1929 J. L. Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 27 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1929, to Feb 27, 1929

~~that I last saw h alive on~~ Dead when I arrived, 19

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Old Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy. Exam.

(Signed) F. E. Hartrick, M. D.

3/1, 1929 (Address) Shoshone

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Shoshone Ida

Date of Burial: Mar 2 1929

20. Undertaker: C. E. Hickok

Address: Shoshone Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65049

Local Registrar's No. 1

PLACE OF DEATH

County of Lincoln
City of Shoshone

Registration District No.
Primary Registration District No.
(No. ~~Street~~ Ice Fall Hotel)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Murphy

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day,
	56			hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant None.
(Address)

15. Filed Feb 13, 1929 J. L. Freer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febr. (Month) 10th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on Feb. 10th, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Chr. Myocarditis
Cor sclerosis

(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) Bronchial pneumonia
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? Baker City, Oregon
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C. Russell Weaver, M. D.
Feb 10, 1929 (Address) Gooding, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shoshone	2-13 1929
20. Undertaker	Address
O. F. Brennan	Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65050

PLACE OF DEATH
County of Madison
City of Rexburg
Registration District No. 100
Primary Registration District No. 2178
(No.)
Local Registrar's No. 1
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Jones

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	8	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Jacob P Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Sarah Cope
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known.

14. Informant John Palmer.
(Address) Rexburg Idaho

15. Filed 2/7, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1928, to Jan. 3, 1929
that I last saw h[illegible] alive on Jan. 2, 1929
and that death occurred, on the date stated above, at 1300 m.
The CAUSE OF DEATH* was as follows:
1. Uremia
2. Old Age.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Enlarged Prostate
with Specific (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A B Eichorn, M. D.
Jan 5, 1929 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Burton Idaho.	Jan 5 1929
20. Undertaker A B Eichorn	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RE[illegible] FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65051

PLACE OF DEATH
County of Madison
City of Rehburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

2. FULL NAME Leslie Ray Sorensen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Infant.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 3 Years, Months 11, Days 23. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Teton Idaho.

PARENTS

10. NAME OF FATHER: Edward P Sorensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah.
12. MAIDEN NAME OF MOTHER: Verna. Neibaur
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho.

14. Informant: Edward P Sorensen.
(Address)

15. Filed 2/7, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 7 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1929, to Jan. 7, 1929
that I last saw him alive on Jan 7, 1929
and that death occurred, on the date stated above, at 4:00 P. m.
The CAUSE OF DEATH* was as follows:
Pneumonia,
1. Emphysema,
2. Mediastinal abscess.
3. Abscess Liver (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (Dr. Kelley) St Anthony sent patient to hospital in Moribund (duration) yrs. mos. ds. condition.

18. Where was disease contracted if not at place of death? Teton
Did an operation precede death? Yes Date of Jan. 7, 29
Was there an autopsy? no
What test confirmed diagnosis? operation
(Signed) [signature], M. D.
Jan 8, 1929 (Address) Rehburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Teton Idaho
Date of Burial: 1/10 1929

20. Undertaker: A B Eckersell
Address

RECEIVED FEB 13 1929

PLACE OF DEATH

County of Madison

City of Rexburg

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

(No. ....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65052

Local Registrar's No. 3

2. FULL NAME Henry Thomas Broomhead Green

(a) Residence. No. .... St. ....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Sarah A Green

6. DATE OF BIRTH (month, day and year) Feb 22 1858

7. AGE	Years	Months	Days	If LESS than 1 day,
	70	10	16	.... hrs. or .... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9. BIRTHPLACE (city or town) (State or country) Tooele Utah

PARENTS

10. NAME OF FATHER Henry Green

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Emma Broomhead

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Sarah A Green

(Address) Burton Idaho

15. Filed 2/7, 1929 J Rigby Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6, 1929, to Jan 7, 1929

that I last saw ~~him~~ alive on Jan 6, 1929

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.... (duration) ? yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

.... (duration) 8 yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of ....

Was there an autopsy? NO

What test confirmed diagnosis? ....

(Signed) A B Sutherland M. D.

1-8, 1929 (Address) Rexburg, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or~~ Removal	Date of Burial
Shipped to Tooele Utah	1/9 1929
20. Undertaker	Address
A B Eckersell	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65054

PLACE OF DEATH

County of Madison

City of Rexburg

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 5

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Byron V. Ricks

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 18, 1928

7. AGE Years | Months 2 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Teton Idaho.

PARENTS

10. NAME OF FATHER: Earl E. Ricks

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Salem Idaho.

12. MAIDEN NAME OF MOTHER: Theora S. Valentine

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salem Idaho

14. Informant: Earl E. Ricks

(Address) Sugar City R.F.D. #1

15. Filed 2/7, 1929 J. Ryoung Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1929, to Jan. 9, 1929

that I last saw him alive on Jan. 8, 1929

and that death occurred, on the date stated above, at 9:00 m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bilateral)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) — Convulsions

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. B. Rigby, M. D.

Jan. 11, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Teton Idaho | Date of Burial: 1/11 1929

20. Undertaker: A. B. Eckersell | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65055

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

2. FULL NAME Grace May Coffing

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6. DATE OF BIRTH (month, day and year) May 1 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	8	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Maid.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Charles B Coffing
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Mary E Watts.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant W. W. Coffing.
(Address) St. Anthony Ida.

15. Filed 2/7, 1929 J Rymer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1929, to Jan. 9, 1929
that I last saw her alive on Jan. 9, 1929
and that death occurred, on the date stated above, at 8:00 P m.
The CAUSE OF DEATH* was as follows:
Cancer Rt. Ovary.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Jan. 9, 1929
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W B Rigby, M. D.
Jan. 11, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Covington Indiana	

20. Undertaker	Address
C B Eckersell	Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65056

PLACE OF DEATH

County of Madison

City of Rexburg R.F.D.-1

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 7

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Willard Brizzie

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Nora Brizzie

6. DATE OF BIRTH (month, day and year) Sept. 17, 1877

7. AGE: Years 51, Months 3, Days 24. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer: Himself

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: Charles Brizzie

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah Hall

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Nora Brizzie
(Address) B Rexburg R.F.D. #1

15. Filed 2/7, 1929 J Rigoring Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-4, 1929, to 1-10, 1929

that I last saw him alive on 1-10, 1929

and that death occurred, on the date stated above, at 9:30 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) W. Sutherland, M. D.

1/12, 1929 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Burton Idaho. Date of Burial: 1/14 1929

20. Undertaker: A B Eckersell Address: Rexburg

FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65057

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No.)
Local Registrar's No. 9

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Berle R. Withers

(a) Residence. No. Rexburg RFD 1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male.	white	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 2/1927

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	7	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Rexburg RFD 3
(State or country)

PARENTS

10. NAME OF FATHER Fred R. Withers
11. BIRTHPLACE OF FATHER (city or town) Farmington Utah
(State or Country)
12. MAIDEN NAME OF MOTHER Lucy Lee
13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)

14. Informant John Lee
(Address) Rexburg RFD 3

15. Filed 2/11, 1929 J. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan 24, 1929, to Jan 26, 1929
that I last saw h[illegible] alive on Jan 26, 1929
and that death occurred, on the date stated above, at 2 AM m.
The CAUSE OF DEATH* was as follows:
Post tal Pneumonia

(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Bronchial Pneumonia
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) David A Rich, M. D.
Jan 26, 1929 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker A B Edwards	Address Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65058

PLACE OF DEATH

County of Madison
City of Sugar City

Registration District No. 100
Primary Registration District No. 2178
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

2. FULL NAME Alice Mabel Goolsby

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of A.C. Goolsby

6. DATE OF BIRTH (month, day and year) Aug. 15. 1865

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63	4	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England.

PARENTS

10. NAME OF FATHER Thomas Curtis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Saunders
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant A.C. Goolsby.
(Address) Sugar City, Idaho.

15. Filed Feb 11, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928, to Feb 6, 1929
that I last saw her alive on Feb 5, 1929
and that death occurred, on the date stated above, at 12:30 p.m.
The CAUSE OF DEATH* was as follows:
Cancer Stomach
Metastases to Left Lung.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H.E. Rigby, M. D.
Feb 8, 1929 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Sugar City Cemetary	2/9 1929
20. Undertaker A B Eckersell	Address Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65059

PLACE OF DEATH

County of Madison
City of Thornton

Registration District No. 100
Primary Registration District No. 2 78
Local Registrar's No. 11
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Katherine Anderson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ John R Anderson

6. DATE OF BIRTH (month, day and year) April 11/1900

7. AGE Years 28 Months 9 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: Peter Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: J. R. Anderson
(Address) Thornton Idaho

15. Filed 2/11, 1929 J Rysburg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-18, 1929, to 1-18, 1929
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Acute Otitis media

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Meningitis

..... (duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Opening of middle ear abcess Date of 1-18-29
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) W Sutherland, M. D.
1-19, 1929 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Leadore Idaho. Date of Burial: 2/19 - 1929

20. Undertaker: B Eckersill Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. RECEIVED MAR 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

File No. 65060

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Holt Nickols

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 7 (Day) 1872 (Year)

7. AGE: 52 Yrs. 4 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmers

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: William C. Nickols

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary Nickols

(Address) Rupert Ida.

15. Filed Feb 14 1929 E. H. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 18 1928, to Sept 18 1928 that I last saw him alive on Sept 18 1928 ~~and that death occurred on the date stated above, at ..... M.~~

The CAUSE OF DEATH* was as follows: Carcinoma of Liver.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Homer T. Rice D.C.

Feb 12 1929 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetry

DATE OF BURIAL: ..... 19 .....

20. UNDERTAKER: W. A. Goodman

ADDRESS: Rupert, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Original / 65060

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 65060
Registered No. 14

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walt Nichols

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 7 (Day) 1876 (Year)

7. AGE: 52 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: William C Nichols

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary Nichols
(Address) Rupert Idaho.

15. Filed Feb 14 1929 E E Johnson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1928 to Sept 18 1928 that I last saw h.m. alive on Sept 18 1928 ~~and that death occurred on the date stated above, at ..... M.~~

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Homer J. Rice D.C. ~~M.D.~~
7-1-1929 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: W. A. Goodman
ADDRESS: Rupert Ida

RECEIVED MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65061

PLACE OF DEATH
County of Minedoka
City of Acequia

Registration District No. 19
Primary Registration District No. 2015
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15

2. FULL NAME John B Kidd

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Annah M Kidd

6. DATE OF BIRTH (month, day and year): Nov. 17, 1859

7. AGE: Years 69 Months 3 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS
10. NAME OF FATHER: Alexander Kidd
11. BIRTHPLACE OF FATHER (city or town) (State or Country): .....
12. MAIDEN NAME OF MOTHER: B Fidelia Bickmore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): .....

14. Informant: Alex Kidd
(Address) Jackson Ida

15. Filed 2-25, 1929 Ett Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1928, to Feb 22, 1929
that I last saw him alive on Feb. 21, 1929
and that death occurred, on the date stated above, at 7 A. m.
The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease
..... (duration) 5 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
..... (duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Ett Elmore M. D.
2-25, 1929 (Address) Rupert, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rupert Ida
Date of Burial: Feb. 25 1929

20. Undertaker: D E Johnson
Address: Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC D MAR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65062

Registration District No. ____
Primary Registration District No. 2015
Local Registrar's No. 16

PLACE OF DEATH
County of Minidoka
City of Heyburn

(No. ____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sylvia Luella Winks

(a) Residence. No. Heyburn Ida. R.F.D. #1 St. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert G Winks

6. DATE OF BIRTH (month, day and year): July 1 1876

7. AGE — Years: 52 | Months: 7 | Days: 5 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ____
(c) Name of employer: ____

9. BIRTHPLACE (city or town) (State or country): Morgan Co Utah

PARENTS

10. NAME OF FATHER: Charles Criddle
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Emma Faye Crofts
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pennsylvania

14. Informant: Albert G Winks
(Address): Heyburn Ida. R.F.D. #1

15. Filed Feb 25, 1929 E H Edmonson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1929 to Feb 21, 1929 that I last saw her alive on Feb 8, 1929 and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Illness (duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary): High Blood Pressure (duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? No Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____

(Signed) Joseph Howard M. D.
Feb 24, 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Heyburn Ida.	Feb 24 1929
20. Undertaker	Address
W. C. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25-M. 1-26-

RECEIVED MAR 4 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Power

City of

Registration District No. 25

Primary Registration District No. 2072

(No. , St.)

File No. 65068

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald David Horton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6. DATE OF BIRTH. May (Month) 30 (Day) 1928 (Year)

7. AGE ..... Yrs. 7 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Power Co, Idaho

10. NAME OF FATHER Frank Horton

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Lena Fackrell

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Horton

(Address) Amer Falls, Idaho

15.

Filed 3 - 1 1929 Genevieve Nott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 17 1929, to Feby 18 1929, that I last saw him alive on Feby 18 1929, and that death occured on the date stated above, at 11a M.

The CAUSE OF DEATH* was as follows:

Entero colitis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

2/18 1929 (Signed) C. F. Schultz M. D.

(Address) Amer. Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Amer Falls

DATE OF BURIAL 2/20 1929

20. UNDERTAKER Family

ADDRESS

SYMS - YORK CO., PTRS. & SDRS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 65069

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Shoshone

City of Kellogg

Registration District No. 123

Primary Registration District No. 2201

(No. .....)

Local Registrar's No. 8

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Fred L. Ruch

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND ~~of (or) WIFE of~~ Mildred Ruch

6 DATE OF BIRTH (month, day and year) Apr.-28-1874

7 AGE Years 55 Months 2 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Linneaus Mo.

PARENTS

10 NAME OF FATHER: Jacob Ruch

11 BIRTHPLACE OF FATHER (city or town) (State or country): ~~Switzerland~~ Penn

12 MAIDEN NAME OF MOTHER: Rebecca Weiniger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Indiana.

14 Informant: Mrs Fred Ruch

(Address) Kellogg Ida

15 Filed 2/28, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 21 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from About, 1916, to Feb 21, 1929, that I last saw him alive on Feb 21, 1929, and that death occurred, on the date stated above, at 8:53 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

About (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Siderosis

About (duration) 13 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Tubercle bacillus in sputum

(Signed) Geo H Kennett, M. D.

Feb 25, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Kellogg Ida

Date of Burial: Feb. 24 1929

20. Undertaker: R. L. Stout

Address: Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65070

PLACE OF DEATH

County of Shoshone

City of Mullan

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 1

(No. Residence)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Andy Kalla

(a) Residence. No. Mullan, Idaho St. Mullan, Ida.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Helma Kalla.

6. DATE OF BIRTH (month, day and year)

7. AGE 38 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Federal Mng. Co.

9. BIRTHPLACE (city or town) (State or country) Finland

PARENTS

10. NAME OF FATHER Not Known.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant Mrs Andy Kalla.

(Address) Mullan Idaho

15. Filed Jan 6, 1929 F. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

that I last saw him alive on ..., 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Found dead with 45 wounds in chest Head Suicidal

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. R. Mowery Coroner

1/2 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mullan, Ida. Date of Burial Jan 6 1929

20. Undertaker J. A. Bever Ward Undertaking Co. Address Wallace, Ida.

RECEIVED FEB 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65071

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1011
(No.)
Local Registrar's No. 2

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Oscar Lasztik

(a) Residence. No. Death at Infirmary St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 If single, Married, Widowed, or divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 55 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10 NAME OF FATHER —
11 BIRTHPLACE OF FATHER (city or town) (State or country) —
12 MAIDEN NAME OF MOTHER —
13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Leroy Massey
(Address)

15 Filed Jan 5, 1929 L. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 2 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 5/26/28, 19..., to 1/2, 1929, that I last saw him alive on 1/2, 1929, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edmund R Brun, M. D.
1/8/29, 19... (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Kellogg Ida — Date of Burial: Jan 5 1929

20. Undertaker: P. L. Stout — Address: Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Public Health Adviser
Food and Drug Inspection
Bacteriological Laboratory
Chemical Laboratory
Sanitary Engineer
Bureau of Child Hygiene
Vital Statistics

DAVID BURRELL, Commissioner

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
Lava Hot Springs, Lava
Idaho Soldiers' Home, Boise
Northern Idaho Sanitarium, Orofino
State School & Colony, Nampa

H. C. BALDRIDGE, Governor

March 19, 1929.

Dr. James R. Bean,
Wallace, Idaho.

Re: 65071

Dear Doctor:

In order to complete the death certificate of OSCAR LASTIK who died at the County Hospital on January 2, 1929, would you kindly advise whether he was

SINGLE, MARRIED, WIDOWED or DIVORCED.

An addressed stamped envelope is enclosed for your convenience in returning this letter with the desired information.

Respectfully yours,

C. K. Macey

C. K. Macey,
State Registrar.

Mr. Macey.

Dear Sir:
Dr. Bean turned your letter over to Mr. Massey Supt. Infirmary. We have no record in relation to the question you ask but an old friend who has known him for years says he was single. The only relative mentioned is a sister Mrs Hannula, Do Range, Mich.

Very Truly,
Mrs L. Massey.
Matron.

Dr. Quigley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65072

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Shoshone — Registration District No. 70

City of Wallace — Primary Registration District No. 1011

(No. Providence Hospital)

Local Registrar's No. 3

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mrs Alice J Raymond

(a) Residence. No. 17 Second street St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas M. Raymond

6 DATE OF BIRTH (month, day and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER Harry M Looney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Illinois

12 MAIDEN NAME OF MOTHER Emma Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Illinois

14 Informant Thos M Raymond

(Address) 17 Second St Wallace Idaho

15 Filed Jan 6, 1929 L. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 5 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1928, to Jan 5, 1929, that I last saw her alive on Jan 4, 1929, and that death occurred, on the date stated above, at 5.45 m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. K. Quigley M. D.

Jan 6, 1929 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Scotts Bluff Neb.	19
20. Undertaker Woratell & Shaughnessy	Address Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65073

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

2. FULL NAME Andy Carlson
(a) Residence. No. Mullan Road Near Wallace Ind.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 57 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway.

PARENTS
10. NAME OF FATHER Carl Ommerson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Gabe Olson
(Address) Wallace, Idaho

15. Filed Jan 17, 1929 S. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11, 1929 to Jan 14, 1929
that I last saw him alive on Jan 13, 1929
and that death occurred, on the date stated above, at 7:00 a m.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Silicosis
(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) James R Bean, M. D.
1/14/29 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace Idaho
Date of Burial Jan 17 1929

20. Undertaker J. A. Bower Ward Mid Inc
Address Wallace Ida

RECEIVED FEB 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65074

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5

2. FULL NAME Elisabeth Savage
(a) Residence. No. Pearl St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Married.

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Chas H. Savage.

6. DATE OF BIRTH (month, day and year)

7. AGE Years 70 Months 1 Days 11 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10. NAME OF FATHER J. Cofer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Not Known.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Clyd Savage.
(Address) Wallace Idaho

15. Filed Jan 18, 1929. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1929 to Jan 15, 1929
that I last saw her alive on Jan 15, 1929
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
arteriosclerosis
general apoplexy &
myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Dr. Mowery M. D.
1/16, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial Jan 18 1929

20. Undertaker J. A. Bever Ward Undertaking Co. Address Wallace Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 20 1929

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65075

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 6
(No. Residence Mullan Road.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joel Mansfield Wilson
(a) Residence No. Near Wallace on Mullan Road St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Gladys Wilson
6. DATE OF BIRTH (month, day and year) Nov 22 - 1899
7. AGE Years 29 Months 2 Days 23 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Supermaid Aluminum Ware
9. BIRTHPLACE (city or town) (State or country) Maquoketa Iowa.

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known.

14. Informant Mrs Gladys Wilson
(Address) Wallace Idaho
15. Filed Jan 19, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

183

16. DATE OF DEATH Jan. (Month) 15 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....
that I last saw him alive on Jan 15, 1929
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:
Gunshot wound of head
(duration) yrs. mos. hrs.
CONTRIBUTORY (Secondary) none
Accidental
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) H. C. Mowery Coroner M. D.
1/16, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Shipped

19. Place of Burial, Cremation, or Removal Maquoketa Iowa Date of Burial Jan 19 1929
20. Undertaker J. A. Bever for Ward Und Co Address Wallace Idaho

Public Health Adviser
Food and Drug Inspection
Bacteriological Laboratory
Chemical Laboratory
Sanitary Engineer
Bureau of Child Hygiene
Vital Statistics

DAVID BURRELL, Commissioner

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
Lava Hot Springs, Lava
Idaho Soldiers' Home, Boise
Northern Idaho Sanitarium, Orofino
State School & Colony, Nampa

H. C. BALDRIDGE, Governor

March 19, 1929.

MAR 25

Dr. H. C. Mowery,
County Coroner,
Wallace, Idaho.

Re: 65075

Dear Doctor:

You gave as the cause of death of JOEL MANSFIELD WILSON who died January 15, 1929, as "GUNSHOT WOUND OF HEAD".

Would you kindly advise whether this was a case of ~~SUICIDE, HOMICIDE or was it~~ ACCIDENTAL. H C Mowery

An addressed stamped envelope is enclosed for your convenience in returning this letter with the desired information.

Respectfully yours,

C. K. Macey

C. K. Macey,
State Registrar.

RECEIVED FEB 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65076

PLACE OF DEATH
County of [redacted]shone
City of Wallace

Registration District No. 70
Primary Registration District No. 1911
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

2. FULL NAME Ramona Eileen Saunders

(a) Residence. No. Kellogg, Idaho St. Kellogg Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace, Idaho

PARENTS

10. NAME OF FATHER Olen Saunders
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Alice Borden
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Colorado

14. Informant Mr Olen Saunders
(Address) Kellogg Idaho

15. Filed Jan 17, 1929 J. H. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1929 to Jan 16, 1929
that I last saw her alive on Jan 15th, 1929
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:
Influenza & meningitis
(duration) yrs. mos. 12 ds.
CONTRIBUTORY (Secondary) Influenza & Mastoiditis
(duration) yrs. mos. 12 ds.

18. Where was disease contracted if not at place of death? at hird
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Epidemic Journ.
(Signed) W. C. Lindsay, M. D.
Jan 16, 1929 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	Jan 17 1929
20. Undertaker J. A Beaver Ward Mtd. Co.	Address Wallace Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65077

Local Registrar's No. 8

PLACE OF DEATH

County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mrs Mable Kays

(a) Residence. No. Lane Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	~~White~~ Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug 1 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	3	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Myrtle Point Oregon

PARENTS

10 NAME OF FATHER Foster J. Poland
11 BIRTHPLACE OF FATHER (city or town) (State or country) Myrtle Point Oregon
12 MAIDEN NAME OF MOTHER Ida Appelton
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sprague Wash.

14 Informant E. O. Kays
(Address) Lane Idaho

15 Filed Jan 18, 1929 W. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Jan (Month) 16 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to Jan 16, 1929, that I last saw h[illegible] alive on Jan 16th, 1929, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:
Surgical shock following operation for removal of Gall Bladder.
(duration) .... yrs. .... mos. 2 ds.
CONTRIBUTORY (Secondary) Gall stones.
(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? Lane Idaho
Did an operation precede death? Yes Date of Jan 15th
Was there an autopsy? Yes
What test confirmed diagnosis? Symptomatology
(Signed) W. B. Linsley, M. D.
1/17, 1929 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Lane Idaho	1-18 1929
20. Undertaker Worstell Co	Address Wallace
J G Shaughnessy	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65078

Local Registrar's No. 9

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 101
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME John N. McPhearson

(a) Residence. No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov 15 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Coeur D'Alene Hdw. Co.

9 BIRTHPLACE (city or town) (State or country) Nova Scotia

PARENTS
10 NAME OF FATHER Not Known
11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Anna Sanders
(Address) Seattle, Wash.

15 Filed Jan 22, 1929 L. P. Luidgett Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Found Jan 18-1929
Dead probably 4 or 5 days previous
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...,
that I last saw him alive on ..., 19...,
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH was as follows: Injured Dec 31 Jan 1 Fell down stairs Fractured left hip Died Jan 18 1929 Duration 18 days
CONTRIBUTORY (Secondary) Had fallen down stairs several times recently
(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) W. Ward Corbett, M. D.
1/18, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho	Jan 22 1929
20. Undertaker J. G. Bever	Address
Ward Undertaking Co.	Wallace, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED FEB 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65079

PLACE OF DEATH

County of Shoshone Registration District No. 70
City of Wallace Primary Registration District No. 1011
(No. Placer Creek) Local Registrar's No. 10
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. **FULL NAME** Edward Simonson

(a) Residence. No. Placer Creek St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept. 9 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Finland

PARENTS

10 NAME OF FATHER Edward Simonson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Finland
12 MAIDEN NAME OF MOTHER Not Obtainable
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Finland

14 Informant Mrs Anna Simonson
(Address) Wallace Idaho

15 Filed Feb 3, 1929 J. P. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
January (Month) 29 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1929, to Jan 29, 1929, that I last saw h.. alive on Jan 29, 1929, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) T. C. Merrill, M. D.
Jan 30 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Sunset Memorial Park Medimont Idaho	Feb 3. 1929
20. Undertaker Worstell Co J. C. Shaughnessy	Address Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Dr Werlich

FORM V. S. [illegible] RECEIVED MAR 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 65081
Registered No. 4

1. PLACE OF DEATH
County of Teton
City of Driggs R.D.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Carrie Menmear

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 25 (Day), 1920 (Year)

7. AGE: 8 Yrs. 6 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: E. C. Menmear

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Violet Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. E. C. Menmear
(Address) Driggs, Idaho

15. Filed 2-28-1929 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18 1929 to Feb. 19 1929 that I last saw h[illegible] alive on Feb. 18 1929, and that death occurred on the date stated above, at 6:00 P.M.
The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) Yrs. 2 mos. — ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 10 ds.

(Signed) L. T. [illegible] M. D.
2/20 1929 (Address) Driggs, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jetonia Idaho
DATE OF BURIAL: 2-21-1929

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAR 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65082

PLACE OF DEATH
County of Teton
City of ~~Driggs~~ Sam.

Registration District No. 77
Primary Registration District No. 9176
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

2. FULL NAME James Watkins
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE: Years 50; Months –; Days –; If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Coal Miner
(b) General nature of industry, business, or establishment in which employed (or employer): " Mining
(c) Name of employer: W. F. Samuels
9. BIRTHPLACE (city or town) (State or country): Wales

PARENTS
10. NAME OF FATHER: DK
11. BIRTHPLACE OF FATHER (city or town) (State or Country): DK
12. MAIDEN NAME OF MOTHER: DK
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): DK

14. Informant: Taken From Game Licence
(Address)

15. Filed 2-28, 1929 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 16 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 12 10 PM
The CAUSE OF DEATH* was as follows:
Unknown
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) John Cavanaugh Corner M. D.
2/16, 1929 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashton Idaho
Date of Burial: 2/20 1929
20. Undertaker: Lewis Kiser
Address: Ashton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65083

PLACE OF DEATH
County of Twin Falls
City of Burley

Registration District No. 39
Primary Registration District No. 2087
(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. _____

2. FULL NAME Thomas Baldwin

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. / yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie Baldwin

6. DATE OF BIRTH (month, day and year) Jan 1st

7. AGE	Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
	51	—	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Mr Baldwin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Jessie Baldwin
(Address) Burley

15. Filed Feb. 13, 1929 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 9 (Day) 1929 (Year) 177

17. I HEREBY CERTIFY, That I attended deceased from remote at all, 19_____
that I last saw h_____ alive on none 19_____
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Arsenic poisoning

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

_____ (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? No Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? Laboratory

(Signed) H. W. McNamee, M. D.
13-Feb —, 1929 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida.	Jan 11 1929
20. Undertaker L. D. Johnson	Address Burley, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65084

PLACE OF DEATH

County of Twin Falls

City of Twin Falls County Hospital

Registration District No. 39

Primary Registration District No. 2087

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Gerber

(a) Residence. No. St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Fred Gerber

6. DATE OF BIRTH (month, day and year) Dec 4th 1898

7. AGE Years 30 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Langenthal Switzerland

PARENTS

10. NAME OF FATHER Fritz Dennler

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Dant Knaw

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Fred Gerber

(Address) Buhl, Ida.

15. Filed Feb. 13, 1929 J. H. Wurfley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 4th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 27, 1929, to Febry 4th, 1929 that I last saw her alive on Febry 4th, 1929 and that death occurred, on the date stated above, at 1:20 a.m.

The CAUSE OF DEATH* was as follows:

Encephalitis Acute (Disintegration of Brain Tissue) (Microscopic Exam.) (duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Buhl Idaho R.R.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Microscopic Examination

(Signed) Duncan L. Hexmeyer M. D.

2/6, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Ida — Date of Burial Feb 6 1929

20. Undertaker L. J. Johnson — Address Buhl

Public Health Adviser
Food and Drug Inspection
Bacteriological Laboratory
Chemical Laboratory
Sanitary Engineer
Bureau of Child Hygiene
Vital Statistics

DAVID BURRELL, Commissioner

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
Lava Hot Springs, Lava
Idaho Soldiers' Home, Boise
Northern Idaho Sanitarium, Orofino
State School & Colony, Nampa

H. C. BALDRIDGE, Governor

March 19, 1929.

Dr. F. W. MacManus,

Buhl, Idaho. Re: 65083

Dear Doctor:

You gave as the cause of death of Thomas Baldwin who died January 9, 1929, as "Arsenic Poisoning".

Was this ACCIDENTAL, SUICIDAL OR HOMICIDAL?

An addressed stamped envelope is enclosed for your convenience in returning this letter with the desired information.

Respectfully yours,

C. K. Macey

C. K. Macey,
State Registrar.

Mr. C. R. Macey,
Boise, Idaho.

Dear Sir:-Mr. Homer Saxon of Twin Falls found the arsenic in his stomach which I had removed from the body acting under instructions from the Coroner, myself voicing the opinion that, things did not appear just right. It may have been suicidal but I have serious doubts. The police have claimed to be working on the case but to date, have failed to produce.

Yours Truly, F. W. MacManus
Buhl, Idaho.

20-Mar-'29

RECEIVED MAR 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65085

PLACE OF DEATH
County of Twin Falls
City of Twin Falls Genl Hospital

Registration District No. 39
Primary Registration District No. 2087
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Micheal Glenn Gladowski

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Nov 4 - 1927

7. AGE Years 1 Months 3 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buhl Ida

PARENTS
10. NAME OF FATHER Micheal Gladowski
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dodge Neb.
12. MAIDEN NAME OF MOTHER Cathrine Heimann
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dodge Neb.

14. Informant Micheal Gladowski
(Address) Rosewort Ida

15. Filed Feb 13, 1929. J. H. Wurfeld Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1929, to Feb 6, 1929
that I last saw him alive on Feb 6, 1929
and that death occurred, on the date stated above, at 7 45 P m.
The CAUSE OF DEATH* was as follows:
Toxemia - intestinal origin
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Rosewort Ida
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) E. L. Barry M. D.
Feb 7, 1929 (Address) Buhl

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Ida
Date of Burial Feb 8 1929

20. Undertaker L. Johnson
Address Buhl Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65086

PLACE OF DEATH

County of Twin Falls
City of Twin Falls County Hospital

Registration District No. 39
Primary Registration District No. 2087
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Joseph Henry Pinkston

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) July 12 -

7. AGE: Years 14 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country): Bruneau Valley Idaho

PARENTS

10. NAME OF FATHER: Fred Pinkston
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Ruth Robertson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Fred Pinkston
(Address): Castleford Ida

15. Filed Feb. 13, 1929. J. H. Murphy, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1929, to 11-Feb, 1929
that I last saw him alive on 10-Feb, 1929
and that death occurred, on the date stated above, at 5 a.m.
The CAUSE OF DEATH* was as follows:
Constriction of bowel about 2 ft from coccum. Shock due of same and operation.
..... (duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of 10-Feb-'29
Was there an autopsy? no
What test confirmed diagnosis? Actual condition
(Signed) T. W. MacMurray M. D.
13-Feb, 1929 (Address) Buhl, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Buhl Idaho | Date of Burial: 2/12 1929

20. Undertaker: J. Johnson | Address: Buhl Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65088

PLACE OF DEATH

County of Twin Falls
City of Kimberly Idaho.

Registration District No. 36
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

2. FULL NAME Mrs. Henrietta Fay

(a) Residence. No. Kimberly, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 16 Th 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
77	77	11	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER James Hill

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Ruth Grimes

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Mrs. Carrie Chapin
(Address) Kimberly Idaho.

15. Filed Feb 15 1929 J M Davie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 4Th. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 5, 1928 to Feb. 4, 1929
that I last saw her alive on Feb. 1 1929
and that death occurred, on the date stated above, at 105 pm
The CAUSE OF DEATH* was as follows:

Bronche-pneumonia, bilateral

(duration) - yrs. - mos. 17 ds.

CONTRIBUTORY (Secondary) Generalized arterio-sclerosis & Senility (duration) 4 yrs. - mos. - ds.

18. Where was disease contracted if not at place of death? - - -
Did an operation precede death? No Date of - - -
Was there an autopsy? No
What test confirmed diagnosis? Clinical course & lab. (Signed) Geo C Hally M. D.
Feb. 8 1929 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Idah	Feb.6 1929
20. Undertaker P.J. Grossman	Address Twin Falls,

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65089

Local Registrar's No. 3

PLACE OF DEATH
County of Twin Falls
City of Kimberly
Registration District No. 36
Primary Registration District No.
(No. at home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Paul Herrera

(a) Residence. No. Kimberly St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 16 1929

7. AGE — Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) ~~R.R. section~~ Laborer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kimberly Idaho

PARENTS

10. NAME OF FATHER Eliseo Herrera
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mex.
12. MAIDEN NAME OF MOTHER Petra Barrera
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mex.

14. Informant Eliseo Herrera
(Address) Kimberly

15. Filed Feb. 23, 1929 J. M. Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17, 1929, to Feb 17, 1929
that I last saw him alive on 19
and that death occurred, on the date stated above, at 10½ A. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage Asphyxia
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) W. C. Waltz, M. D.
Feb 18, 1929 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Feb 18 1929
20. Undertaker: O. F. Grossman — Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65090

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No. 40
(No. Co. Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jerome Frazelle
(a) Residence. No. 461 3rd Ave. West St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 26 1903
7. AGE Years 25 Months 7 Days 29 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) N.C.

PARENTS
10. NAME OF FATHER P. D. Frazelle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.C.
12. MAIDEN NAME OF MOTHER Atha King
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.C.

14. Informant P. D. Frazelle
(Address) 461 3rd Ave West
15. Filed 3-10-, 1929 W. N. Leeth Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 25 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 19", 1929, to Feb. 25, 1929
that I last saw him alive on Feb. 25, 1929
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Cerebro-spinal meningitis
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. D. Weaver, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial Feb. 27 1929
20. Undertaker P. J. Grossman
Address Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED MAR 11 1929

DO NOT WRITE IN THIS SPACE
State File No. 65091

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 39

2. FULL NAME Wm S. Lewis
(a) Residence. No. Twin Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 3

7. AGE Years: 73 Months: 1 Days: 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Money
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS
10. NAME OF FATHER: Daniel Lewis
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn
12. MAIDEN NAME OF MOTHER: Mary Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn

14. Informant: Hazel Miller
(Address) Twin Falls

15. Filed 3-10-, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Body found dead in feed lot. Badly Mutilated by Hogs (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Coroners Jury gave Cause of death Unknown (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Supposition Was
Did an operation precede death? Date of
Was there an autopsy? Heart failure
What test confirmed diagnosis?
(Signed) Fred E Drake Coroner, M. D.
Mar 2, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetry
Date of Burial: Mar 3 1929

20. Undertaker: F E Drake
Address: Twin Falls

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65092

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 3-1
Primary Registration District No. 1085
Local Registrar's No. 38
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John W. Case
(a) Residence. No. 335 - 4th Ave E. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Josephine Case

6. DATE OF BIRTH (month, day and year) June 23 - 1850

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	8	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ills. (State or country)

PARENTS
10. NAME OF FATHER James Case
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ills
12. MAIDEN NAME OF MOTHER Jane Nevins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ills.

14. Informant C. W. Case
(Address) Kimberly

15. Filed 3-10-, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1927, to Feb 28, 1929
that I last saw him alive on Feb 28, 1929
and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:
1. Arteris Sclerosis
2. Valvular Heart Disease
2. Senile gangrene + leg
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H W Wilson, M. D.
March 1, 1929 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	Mch 3 1929
20. Undertaker	Address
White Mortuary	Twin Falls,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65093

Local Registrar's No. 37

PLACE OF DEATH

County of Twin Falls

City of Do.

Registration District No. 37

Primary Registration District No. 1085

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Max Brockstedt

(a) Residence. No. Idaho Rooms St.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 20 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	7	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Hans Brockstedt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Minnie Lindmann

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Chas Brockstedt

(Address) Twin Falls Idaho

15. Filed 3-10-, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1929, to Feb 22, 1929

that I last saw h[illegible] alive on Feb [illegible], 1929

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W. Stinchfield M. D.

Feb 22, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	3/25- 1929
20. Undertaker	Address
White Mortuary	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65094

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No. 36
(No. 270 Van Buren St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Elmo Peterson

(a) Residence. No. 270 Van Buren St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) July 15 1913

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
15	7	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer Walt Beckley

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER E Peterson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Alice Shumway

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant E J Peterson
(Address) Twin Falls

15. Filed 3-10-, 1929 H. N. Leet Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 19 1929 4.30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15, 1929, to Feb. 19, 1929
that I last saw h~~am~~ alive on Feb. 19, 1929
and that death occurred, on the date stated above, at 4.30 ~~1~~ p. m.
The CAUSE OF DEATH* was as follows:

Meningitis
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 21 ds.

18. Where was disease contracted if not at place of death? Twin Falls Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Test of Spinal Fluid
(Signed) Dr F B Morgan, M. D.
Feb 21, 1929 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Feb 22 1929
20. Undertaker J E Drake	Address Twin Falls

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65095

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1885
Local Registrar's No. 35

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Theo Marsh

(a) Residence. No. 448 3rd Ave S St.
(Usual place of abode)
Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Aug 15

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Galveston (State or country) Indiana

PARENTS

10. NAME OF FATHER Harrison Marsh.
11. BIRTHPLACE OF FATHER (city or town) Indiana (State or Country)
12. MAIDEN NAME OF MOTHER Margaret Harper
13. BIRTHPLACE OF MOTHER (city or town) Indiana (State or Country)

14. Informant Lora Ross
(Address) Twin Falls Ida.

15. Filed 3-10-, 1929 H. N. Leet Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 11 9.20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1928, to Feb. 11, 1929
that I last saw him alive on Feb 11, 1929
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Chas. R. Scott, M. D.
Feb 12, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	Feb 13 1929
20. Undertaker H. Drake	Address Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65096

PLACE OF DEATH

County of Twin Falls

City of Do

Registration District No. 37

Primary Registration District No. 2885

Local Registrar's No. 34

(No. Residence 3 miles S.E. of T.F.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Guy Carleton Andrews.

(a) Residence. No. 2 S. 1-E of Twin Falls St. Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Myrtle Andrews

6. DATE OF BIRTH (month, day and year) Dec 20-1876

7. AGE Years 55 Months 2 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER William Andrews

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mary Hill

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Mrs. Ida Andrews
(Address) Twin Falls, Idaho

15. Filed 3-11-, 1929. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1920, to Feb 21, 1929 that I last saw him alive on Feb 18, 1929 and that death occurred, on the date stated above, at 3:10 A.m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood counts.

(Signed) J. E. Langenwalter, M. D.

Feb 21, 1929 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls County — Date of Burial 2/23 1929

20. Undertaker White [illegible] — Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 34

Primary Registration District No. 1085

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65097

Local Registrar's No. Wilson

2. FULL NAME Anson J. Bentley

(a) Residence. No. 1403 8th East St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 30 1857

7. AGE Years 71 Months 6 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER George B. Bentley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Sarah Buck

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs. Mary Dunham
(Address) Twin Falls Idaho

15. Filed 3-10-, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1929, to Feb 18, 1929, that I last saw him alive on Feb 18, 1929 and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W. Wilson, M. D.

Feb 20, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Cemetery — Date of Burial 2/22 1929

20. Undertaker White Mortuary — Address T. F.

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65098

PLACE OF DEATH
County of Twin Falls
City of ~~Hollister~~ Amsterdam

Registration District No. 39
Primary Registration District No. 2085
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 32

2. FULL NAME N H Sietsema
(a) Residence. No. Amsterdam St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 13 1872

7. AGE Years 56 Months 3 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Holland

PARENTS
10. NAME OF FATHER: G Sietsema
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Holland
12. MAIDEN NAME OF MOTHER: H. Lanting
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Holland

14. Informant: A E Kunkel
(Address) Amsterdam

15. Filed 3-10-, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

6. Pm

16. DATE OF DEATH Feb (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1920, to Feb 14th, 1929
that I last saw him alive on Jan. 3 29, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Valvular heart disease
..... (duration) 20 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) [illegible] M. D.
....., 19.... (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery
Date of Burial: Feb 18 1929

20. Undertaker: J E Drake
Address: Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65099

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No. 1
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Harris Wilson Brown

(a) Residence. No. Filer St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 23 / 1914

7. AGE Years 14 Months 2 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Student
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER L H Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) W V
12. MAIDEN NAME OF MOTHER Blanch Harris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) W V

14. Informant L. H. Brown
(Address) Filer

15. Filed 3-10-, 1929 H. N. Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 8 1929 12 P m
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31st, 1929, to Feb 8th, 1929
that I last saw him alive on Feb. 8th, 1929
and that death occurred, on the date stated above, at 12:05 a.m.
The CAUSE OF DEATH* was as follows:
Hedemus Cerebro
Spinal Meningitis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Date of —
Was there an autopsy? ✓
What test confirmed diagnosis? Laboratory
(Signed) [illegible], M. D.
2-16, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer Cemetary — Date of Burial: Feb 10 1929

20. Undertaker: F. E. Drake — Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65100

PLACE OF DEATH
County of Twin Falls
City of Twin Falls,

Registration District No. 897
Primary Registration District No. 1685
(No. County General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

2. FULL NAME Fred Arthur Dunlap

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Black Negro
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 10th 1929

7. AGE: Years | Months | 2 Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Twin Falls, Idaho

PARENTS

10. NAME OF FATHER Fred Dunlap

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark.

12. MAIDEN NAME OF MOTHER Jeanette Walker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Fred Dunlap
(Address) Twin Falls, Idaho.

15. Filed 3-11-, 1929 T. G. Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10th, 1929, to Feb 12, 1929
that I last saw h. alive on Feb. 12, 1929
and that death occurred, on the date stated above, at 11 PM. m.

The CAUSE OF DEATH* was as follows:
Melena neonatarum
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Non-coagulability of blood.
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical evidence

(Signed) Jason F. Curaflin, M. D.
2-14, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls, Ida. | Date of Burial: Feb 14 1929

20. Undertaker P. J. Grossman | Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

D SPACE

Sta File No. 651

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 51

Primary Registration District No. 1425

Local Registrar's No. 29

(No. County General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Max Vernon Frazelle

(a) Residence. No. 461 --3Rd. Ave, West, St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 26- 1922

7. AGE	Years	Months	Days	If LESS than 1 day,
	6	11	10	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Twin Falls Ida.

PARENTS

10. NAME OF FATHER P.D. Frazelle

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. C.

12. MAIDEN NAME OF MOTHER Atha King

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. C.

14. Informant P.D. Frazelle,

(Address) 461-- 3Rd. Ave, West. Twin Falls,

15. Filed Mar 11, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 6th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Jan 6, 1929

that I last saw him alive on Jan 6, 1929

and that death occurred, on the date stated above, at 630pm

The CAUSE OF DEATH* was as follows:

Cerebro Spinal meningitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? School

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Spinal puncture

(Signed) J. L. Langdurwalter, M. D.

Feb 11, 1929 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Ida.	Jan 9 1929
20. Undertaker P.J. Grossman	Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65102

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 57
Primary Registration District No. 1 (or)
(No. Twin Falls County Hospital)
Local Registrar's No. 15
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dell Wilson Davis

(a) Residence. No. Route #2 Buhl, Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 3 - 1918

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
10	2	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Buhl Idaho
(State or country)

PARENTS

10. NAME OF FATHER Elza Curtis Davis
11. BIRTHPLACE OF FATHER (city or town) Mo.
(State or Country)
12. MAIDEN NAME OF MOTHER Blanche Keith
13. BIRTHPLACE OF MOTHER (city or town) Ark.
(State or Country)

14. Informant Dr. Ora D. Keith
(Address) Twin Falls, Ida.

15. Filed Mar 11, 1929 J. P. Brandt
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1929, to Feb. 14, 1929
that I last saw him alive on Feb. 14, 1929
and that death occurred, on the date stated above, at 11:30 P. m.
The CAUSE OF DEATH* was as follows: Meningitis - Contagious
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) J. H. Murphy, M. D.
2-15-, 1929 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls cemetery	Feb 16 1929
20. Undertaker	Address
White Mortuary	Twin Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65103

RECEIVED MAR 1 1929

PLACE OF DEATH

County of Twin Falls

City of Do

Registration District No. 87

Primary Registration District No. 495

Local Registrar's No. 27

Dr. Morgan

(No. Twin Falls Co Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lonnie Frazier

(a) Residence. No. Morristown, Tenn. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 6/15/1911

7. AGE Years 17 Months 7 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Morristown Tenn.

PARENTS

10. NAME OF FATHER John Frazier

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Rachel Green

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant John Frazier

(Address) Twin Falls.

15. Filed 3-10-, 1929 H. M. Neel Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13, 1929, to Feb. 14, 1929

that I last saw him alive on Feb 14, 1929

and that death occurred, on the date stated above, at 12:05 A.m.

The CAUSE OF DEATH* was as follows:

Meningitis

24 hours (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza

3 Weeks previous (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Contracted in Twin Falls

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal Fluid

(Signed) Dr J R Morgan, M. D.

Feb. 15, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls cemetery

Date of Burial 2/15 1929

20. Undertaker White Mortuary

Address Twin Falls Ida.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Twin Falls

If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAR 11 1929

Registration District No. 37

Primary Registration District No. 1085

(No. ..... St.)

File No. 65104

Registered No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucille Clifton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: June (Month) 20 (Day) 1906 (Year)

7. AGE: 22 Yrs. 7 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: M. V. Carnell

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Susan Ehstin

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Clifton

(Address) Buhl RFD #2

15.

Filed 3-10 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 11 1929, to Feb. 14 1929, that I last saw her alive on Feb. 14 1929, and that death occurred on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows: Embolism at base of brain

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Following Laparotomy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Murphy M. D.

2-14 1929 (Address) Buhl Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Neosho, Mo.

DATE OF BURIAL 19

20. UNDERTAKER: P. J. Grossman

ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65105

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 24

2. FULL NAME Cecilia Adelaide Gatz
(a) Residence. No. 241 Fourth Ave East St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) June 9, 1879
7. AGE Years 49 Months 8 Days 8 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —
9. BIRTHPLACE (city or town) (State or country) Quincy, Ill
PARENTS
10. NAME OF FATHER August A. Gatz
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Laura Rautenberg
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany
14. Informant Dr Geo C Halley
(Address) 241 Fourth Ave East
15. Filed 3-10-, 1929. H. N. Leetz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 1st (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov., 1927, to Feb 1, 1929
that I last saw her alive on Feb 1, 1929
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows: Carcinoma right breast
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) General Carcinomatosis
(duration) 1½ yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of Nov 9 1926
Was there an autopsy? no
What test confirmed diagnosis? History & Clinical Progress
(Signed) Geo C Halley M. D.
Feb 2, 1929 (Address) Twin Falls, Ill

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Cemetery Date of Burial Feb 4 1929
20. Undertaker J E Drake Address T Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65106

PLACE OF DEATH

County of Twin Falls,

City of Kimberly,

Registration District No. 36

Primary Registration District No.

(No. Kimberly, Idaho.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Clarence A. Johnson

(a) Residence. No. Kimberly, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept. 11 Th. 1876

7. AGE: 52 Years 4 Months 6 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: John Albert Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Martha Smoot

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri.

14. Informant: Mrs C. A. Johnson
(Address) Kimberly Idaho.

15. Filed Jan. 18, 1929 J. N. Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan - 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov - 1 - 1928 to Jan - 16 1929
that I last saw him alive on Jan - 16 - 1929
and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Sigmoid (Primary)
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinoma of liver retro-peritoneal lymphatic glands and kidneys (duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy + laboratory

(Signed) J. N. Davis, M. D.

1/17, 1929 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls, Idaho. Date of Burial: Dec. 19 1929

20. Undertaker: P. J. Grossman Address: Twin Falls, Idaho.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED FEB 26 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 15

County of Valley

Primary Registration District No.

File No. 65112

City of Cascade Ida (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Lee Watson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 12 (Day) 1861 (Year)

7. AGE: 68 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Farmer City Ill

10. NAME OF FATHER: Wm W Watson

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Myron Watson

(Address) Cascade Idaho

15. Filed 19 Stella Cain Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Dec.~~ Jan (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1929, to Dec. 10 1929, that I last saw him alive on Dec. 10 1929, and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) N. A. Olsen M. D.

19 (Address) Cascade

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Alpha Idaho

DATE OF BURIAL: Jan 12 1929

20. UNDERTAKER: Wm McBratney A.D.T.

ADDRESS: Boise Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED FEB 27 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE — Registration District No. .....
County of Washington — Primary Registration District No. .....
City of Moderate — (No. ....., ... St.)
File No. 65113
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilbert Caseldine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. (Month) (Day) 1/ 1854 (Year)
7. AGE 75 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country) Indianna
10. NAME OF FATHER John Caseldine
11. BIRTHPLACE OF FATHER (State or Country) dont Know
12. MAIDEN NAME OF MOTHER Amanda Ross
13. BIRTHPLACE OF MOTHER (State or Country) Ohio
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lawrence Caseldine
(Address) Moderate Idaho
15. Filed Feb 27 1929 Le K. Macey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Feb. (Day) 20 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 20 (1929) to Feb 20 1929, that I last saw h[illegible] alive on Feb 20 1929 and that death occured on the date stated above, at 5.50 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia 1
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Old age
(Duration ..... yrs. ..... mos. ..... ds.
Feb 20 1929 (Signed) C O Dunnebeck M. D.
(Address) Nussey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Midvale Idaho — DATE OF BURIAL: Feb 23 1929
20. UNDERTAKER: T J Rogers — ADDRESS: Midvale Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRD - YOST CO., PTGS. & ENGS. 24864

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65117

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

2. FULL NAME Rachel Godsby

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm Godsby

6. DATE OF BIRTH (month, day and year) Sept 9-1841

7. AGE Years 87 Months 3 Days 26 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) London Canada

PARENTS
10. NAME OF FATHER Alexander Cameron
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Mary Murray
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant C. C. Godsby
(Address) Weiser Ida

15. Filed Jan 4th, 1929. M. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Jan 4, 1929
that I last saw her alive on Jan 4, 1929
and that death occurred, on the date stated above, at 7 A m.
The CAUSE OF DEATH* was as follows:
Senility
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) C. C. Conant, M. D.
Jan 5/29, 19 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hillcrest Cemetery
Date of Burial: 1-6 1929

20. Undertaker: L. C. Northam
Address: Weiser Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65118

RECEIVED MAR 1 1929

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 56
Primary Registration District No. 1010
Local Registrar's No. 5
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred le Burgdorf.

(a) Residence. No. 56 - West Pool St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Jeanette Burgdorf

6. DATE OF BIRTH (month, day and year) Nov 22 - 1838

7. AGE Years	Months	Days	If LESS than 1 day,
90	1	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Hotel Man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Judith Conant
(Address) Weiser Idaho

15. Filed Jan 3rd, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24th, 1928, to Jan 2nd, 1929
that I last saw h~~is~~ alive on Jan 1st, 1929
and that death occurred, on the date stated above, at 9 A m.
The CAUSE OF DEATH* was as follows:
Senility
(duration) Several yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Bronchitis
(duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. R. Hamilton M. D.
Jan 3rd, 1929 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Portland, Ore.	1 - 5 - 1929
20. Undertaker L. L. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65119

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

2. FULL NAME Harry William Wulff
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Wkr
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ann Elizabeth Wulff
6. DATE OF BIRTH (month, day and year) Mar. 20-1882
7. AGE Years 46 Months 9 Days 16 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hardware Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Boke Oregon

PARENTS
10. NAME OF FATHER Samuel Wulff
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Emmeten Hass
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Ann Elizabeth Wulff
(Address) Weiser. Idaho
15. Filed Jan 7th, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 6 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 15th, 1928, to Jan 6th, 1929
that I last saw him alive on Jan 6th, 1929
and that death occurred, on the date stated above, at 5:30 P m.
The CAUSE OF DEATH* was as follows:
Endocarditis together with aneurism of ascending aorta
(duration) 2(?) yrs. mos. ds.
CONTRIBUTORY (Secondary) Rupture of aneurism (?)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X Ray diagnosis
(Signed) W. R. Hamilton M. D.
Jan 7th, 1929 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial 1-9-1929
20. Undertaker L. C. Northam — Address Weiser Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65120

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 56
Primary Registration District No. 1910
(No. Merchant Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

2. FULL NAME Eva Daisy Warner

(a) Residence. No. Bear Idaho St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ~~Male~~ F.
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Warner

6. DATE OF BIRTH (month, day and year) Aug. 13-1890

7. AGE 38 Years 4 Months 20 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Frank Shelton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Sallie Sater
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash.

14. Informant Earl Shelton
(Address) Bear Idaho

15. Filed Jan 18, 1929 W. H. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9, 1929, to Jan 12, 1929
that I last saw her alive on Jan 12, 1929
and that death occurred, on the date stated above, at 4:45 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? — Date of
Was there an autopsy? —
What test confirmed diagnosis?

(Signed) W. D. Marshall, M. D.
Jan 14, 1929 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bear — Idaho | Date of Burial: Jan 14 1929

20. Undertaker: L. C. Northam | Address: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65121

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 56
Primary Registration District No. 1010

Local Registrar's No. 1

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Geraldine Alma Wayne

(a) Residence. No. 185 E Commercial St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 4 - 1928

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
—	3	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Marion Wayne
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colorado
12. MAIDEN NAME OF MOTHER Alma Larson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Washington

14. Informant Marion Wayne
(Address) Weiser Ida

15. Filed Jan 14th, 1929 W. B. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1929, to Jan. 14, 1929
that I last saw her alive on Jan 14, 1929
and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:
acute indigestion.
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Influenza fever.
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Fa Schmit, M. D.
Jan 15, 1929 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	15 1929
20. Undertaker W. C. Northam	Address Weiser Ida

RECEIVED MAR 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65122

PLACE OF DEATH
County of Washington
City of Weiser
Registration District No. 56
Primary Registration District No. 1010
Local Registrar's No. 9
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Robert Turner

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX: M
4. COLOR OR RACE: Wht
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Mabel Turner

6. DATE OF BIRTH (month, day and year): Dec 19-1889

7. AGE: Years 39 | Months — | Days 29 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mo

PARENTS
10. NAME OF FATHER: George Turner
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn.
12. MAIDEN NAME OF MOTHER: Sarah E Kirkpatrick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo

14. Informant: Mrs John S. Boyd
(Address) Challis Ida

15. Filed Jan 15 1929 W. R. Thornton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1929, to Jan 15, 1929
that I last saw h~~im~~ alive on Jan 15, 1929
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Diabetes Coma
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. W. Marshall M. D.
Jan 16, 1929 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	1-17 1929
20. Undertaker: L. C. Northam	Address: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REC'D MAR 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65123

PLACE OF DEATH
County of Washington
City of Weiser
Registration District No. 5
Primary Registration District No. 1912
Local Registrar's No. 10
(No. Monroe Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Melinda Bradshaw
(a) Residence. No. Mann Creek St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX: F
4. COLOR OR RACE: Wht
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Herman Bradshaw

6. DATE OF BIRTH (month, day and year): July 25-1855

7. AGE: Years 73 | Months 8 | Days 25 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: Don't Knowed
11. BIRTHPLACE OF FATHER (city or town) (State or Country): don't Know
12. MAIDEN NAME OF MOTHER: Adelaide Gibson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: Lulu McMahon
(Address): Council Idaho

15. Filed Jan 21 1929 W. A. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 20th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18th, 1928, to Jan 20th, 1929
that I last saw her alive on Jan 19th, 1929
and that death occurred, on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:

Myocarditis,

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary): Arteriosclerosis
(duration) Years yrs. mos. ds.

18. Where was disease contracted if not at place of death? At Residence
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) W. A. Hamilton M. D.
Jan 21, 1929 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	1-22 1929
20. Undertaker: L. C. Northam	Address: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65125

PLACE OF DEATH

County of Washington

City of Weiser

Registration District No. 56

Primary Registration District No. 1010

Local Registrar's No. 12

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ada Eva Poole

(a) Residence. No. Huntington St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE wht

5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 18-1929

7. AGE Years — Months — Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER James C Poole

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Texas

12. MAIDEN NAME OF MOTHER Mabel May Blakely

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon

14. Informant Clay Blakely

(Address) Weiser Ida R7D #4

15. Filed Feb 1st, 1929 M. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 25th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1929, to Jan 25, 1929 that I last saw her alive on Jan 24, 1929 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Icterus of New Born

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F A Schmidt M. D.

Jan. 26, 1929 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hillcrest Cemetery — Date of Burial: 1-27 1929

20. Undertaker: L. C. Northam — Address: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MAR 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65126

65126

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 80

(No. U.S.Veterans' Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James W. Gardiner

(a) Residence. No. ..... St. Locke, Wash.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. X yrs. X mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 26, 1899

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
29	2	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington

PARENTS

10. NAME OF FATHER Nathaniel Gardiner (deceased)

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Emily Spencer (deceased)

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant D.W.Herron

(Address) U.S.V.Hospital, Boise, Idaho.

15. Filed 3/14/, 1929 Linda McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 13, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from March 8, 1929, to March 13, 1929 19

that I last saw him alive on March 13, 1929, 19

and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) XX

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? ~~XX~~

(Signed) F. B. Brewer, M. D.

Mar. 14, 1929, 19 ..... F. B. BREWER
MEDICAL OFFICER IN CHARGE
U. S. VETERANS' HOSPITAL
BOISE, IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Newport, Wash.

Date of Burial: 19

20. Undertaker: W.McBratney

Address: BOISE, IDAHO

RECEIVED MAR 19 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

65127

DO NOT WRITE IN THIS SPACE
State File No. 65127

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 85

(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred O. Beckman

(a) Residence. No. ..... St. Burley, Ida
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) February 19-1887

7. AGE Years 42 Months — Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) South Dakota

PARENTS

10. NAME OF FATHER G. W. Beckman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Miss Nellie Greeley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn.

14. Informant Mrs C C Tyler
(Address) R.R. #5 Boise, Ida.

15. Filed 3/13/ 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 — 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 3, 1929, to Mch 10, 1929 that I last saw him alive on Mch 9, 1929 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary Type

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W L Draper, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery — Date of Burial 3/14 1929

20. Undertaker Schreeber & McCann — Address Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

(15128)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65128

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St.)

2. FULL NAME Margaret P. Depper

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

6. DATE OF BIRTH: Sept (Month) 17 (Day) 1859 (Year)

7. AGE: 69 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF Father: Moses Henery

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Mary A McCain

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Depper

(Address) Nampa Idaho

15.

Filed 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1929, to Feb. 25 1929

that I last saw her alive on Feb. 25 1929

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows: Pneumonia (lobar)

(Duration) yrs. 1 mos. 3 ds.

Contributory (Secondary) General debility

(Duration) Some yrs. mos. ds.

(Signed) Jack Proctor M. D.

2 28 1929 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. DATE OF BURIAL: 2-27 1929

20. UNDERTAKER: Fred K. Robinson ADDRESS: Nampa Ida

65129

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65129

PLACE OF DEATH
County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 2161
(No. GENERAL HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 5507

2. FULL NAME WALTER FRANSEN

(a) Residence. No. OGDEN UTAH St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) DEC. 7 1890

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	2	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work SHEEPHERDER
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) HUNTSVILL UTAH

PARENTS
10. NAME OF FATHER JENS. C FRANSEN
11. BIRTHPLACE OF FATHER (city or town) (State or Country) DENMARK
12. MAIDEN NAME OF MOTHER ANN MARIA EPSEN
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UTAH

14. Informant MRS. MARGARET FRANSEN
(Address) POCATELLO IDAHO

15. Filed 2/18/29 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH FEBRUARY 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/16, 1929, to 2/15/29, 19..
that I last saw h[illegible] alive on 2/15/29, 19..
and that death occurred, on the date stated above, at 1 9 1 m.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
Pneumonia

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? NO
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis?
(Signed) [signature] M. D.
2/16, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
HUNTSVILL UTAH	FEB. 20 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 22 1929

65-130

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65130

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 94

PLACE OF DEATH

County of Ada

City of Boise

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Julia Culbertson Roberts

(a) Residence. No. 214 East Jefferson St.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 18-1846

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	2	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10. NAME OF FATHER Alexander Culbertson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn

12. MAIDEN NAME OF MOTHER Mary Nathalie

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montana

14. Informant Margaret S. Roberts

(Address) 214 E. Jefferson St. Boise Idaho

15. Filed 3/20/1929 Paula M. Doane Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/1, 1929, to 3/16, 1929

that I last saw h[illegible] alive on 3/16, 1929

and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Senile

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Fred. A. Painter M. D.

3/19, 1929 (Address) Boise Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Mar. 19 1929

20. Undertaker: Summers & Krebs — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

65131

RECEIVED MAR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65131

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 93
(No. U.S. Veterans' Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter J. Merriam

(a) Residence. No. U.S.V.Hospital St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Divorced

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Merriam

6. DATE OF BIRTH (month, day and year) April 23, 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	10	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hospital Head Orderly
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER George D. Merriam

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER Rena Giles

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant D.W.Herron
(Address) U.S.V.Hospital, Boise, Idaho

15. Filed 3/20/29 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 18, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 14, 1929, 19..., to Mar. 18, 1929, 19...
that I last saw h im alive on Mar. 18, 1929, 19...
and that death occurred, on the date stated above, at 6:50 A.M. m.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? Boise, Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? XX

(Signed) [signature], M. D.
Mar. 19, 1929, 19... (Address) MEDICAL OFFICER IN CHARGE U.S. VETERANS' HOSPITAL BOISE, IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parma, Idaho	3-20-29 19

20. Undertaker	Address
W.McBratney	Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 23 1929

65732

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65132

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2107

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter N. Hughes

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Olive Hughes

6. DATE OF BIRTH (month, day and year) Dec 4 1894

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	3		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Civil Engeneer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tronto Canada

PARENTS

10. NAME OF FATHER John Hughes

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER Elizabath Love

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant Mrs Olive Hughes

(Address) Orofino Ida

15. Filed Mar 8, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 4, 1929, to Mar. 8, 1929

that I last saw h~~im~~ alive on Mar 8 1929

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 8 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P. J. Hopkins, M. D.

Mar 8, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Mar 10 19
20. Undertaker W. A. Shaw	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

65133

RECEIVED MAR 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 65133

PLACE OF DEATH

County of Latah

City of Moscow

CERTIFICATE OF DEATH

Registration District No. 101

Primary Registration District No. 1011

(No. County Jail)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 12

2. FULL NAME Eugene E. Willis

(a) Residence. No. ..... St. Lewiston, Ida.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct. 5, 1891

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
37	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Canton Ill.

PARENTS

10 NAME OF FATHER Alonzo Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ill.

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ill.

14 Informant Joe Mc Farland

(Address) New Canton, Ill.

15 Filed Mch 5, 1929 W. H. Barthers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 3 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26 Ot, 1929, to Mar. 3rd, 1929, that I last saw ~~him~~ alive on Mar 3rd, 1929, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows: Angina Pectoris.

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Debility due to morphine + alcohol

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) J. W. Stevenson M. D.

March 4 1929 (Address) W. A. Glair Moscow Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place ~~of Burial or Removal~~ New Canton, Ill

Date of Burial 19

20. Undertaker H. R. Short

Address Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

65134 Rgd.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65134

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Bertha Tiemeyer
(a) Residence. No. Peck Idaho St. Peck Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of W. F. Tiemeyer

6. DATE OF BIRTH (month, day and year) Jan 18 1902

7. AGE Years 26 Months 11 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fort Wendall Minn.

PARENTS
10. NAME OF FATHER John Merkling
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant Mrs R. Hainey
(Address) Marshfield Ore.

15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan - 3, 1929, to Jan - 10, 1929
that I last saw her alive on Jan - 9, 1929
and that death occurred, on the date stated above, at 10 m.
The CAUSE OF DEATH* was as follows:
Strepto - Staphylococcus infection
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Influenza
Baby Stillborn Jan 8 - 1929 (duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. M. Lyle M. D.
1-12, 1929 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 1/14 1929

20. Undertaker Vassar Hud Co.
Address Lewiston Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MAR 27 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

65134

DO NOT WRITE IN THIS SPACE

State File No.

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. St. Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Bertha Tiemeyer

(a) Residence. No. Peck Idaho St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: W. F. Tiemeyer

6. DATE OF BIRTH (month, day and year)

7. AGE: ~~26~~ Years: 26 Months: 11 Days: 25. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Fort Wendale Minn

PARENTS

10. NAME OF FATHER: John Merkling

11. BIRTHPLACE OF FATHER (city or town) (State or Country): X

12. MAIDEN NAME OF MOTHER: X

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): X

14. Informant: Mrs Haeney

(Address): Mansfield Ore

15. Filed Feb 9, 1929 Susan E Bruce Registrar

Copy of the Original Susan E Bruce

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1929, to 10, 1929

that I last saw her alive on Jan 9, 1929

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Salpingitis

Infection

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of no

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John M. Lyle, M. D.

1.10., 1929 (Address) Lewiston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Vassar's Und. Co — Date of Burial: 1-14-1929

20. Undertaker: Lewiston — Address: Lewiston

RECEIVED MAR 27 1929

65135

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65135

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2008

Local Registrar's No. 10

(No. Idaho State Soldiers Home.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hugh A. Taylor.

(a) Residence. No. 608 Washington. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Virginia Taylor.

6. DATE OF BIRTH (month, day and year): Nov. 24th 1842.

7. AGE: 86 Years | Months: 3 | Days: 18 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ohio.

PARENTS

10. NAME OF FATHER: John T. Taylor.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Jane Grier.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio.

14. Informant: Mrs. H. A. Taylor.
(Address) 608 Washington St. Boise, Idaho.

15. Filed 3/18/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 12th 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1929, to 3/12, 1929
that I last saw him alive on , 19
and that death occurred, on the date stated above, at 10 P.M m.
The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Fred A Pfaunger, M. D.

3/13/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. | Date of Burial: 3/18/29 19

20. Undertaker: Wm. McBratney. | Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

65136

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65136

RECEIVED MAR 15 1929

PLACE OF DEATH

County of Shoshone Registration District No. 70

City of Wallace Primary Registration District No. 10 01

Local Registrar's No. 19

(If death occurred in a hospital or institution, give its name instead instead of street and number.) (No. Shoshone County Infirmary)

2. FULL NAME J. R. Jackson

(a) Residence. No. ..... St. .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec 17 - 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Sunshine Mining Co

9 BIRTHPLACE (city or town) (State or country) Sudbury Ontario

PARENTS

10 NAME OF FATHER Andrew Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ontario Canada

12 MAIDEN NAME OF MOTHER Sara Jane Hitchcock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eyebrook Ont Canada

14 Informant Jessie Jackson Sister of Deceased

(Address) 11131 99 Ave Edmonton Alberta Can

15 Filed 2 26, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 30 (Day) 29 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929, to Jan 30, 1929, that I last saw him alive on Jan 29, 1929, and that death occurred, on the date stated above, at 9 am m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Silicosis 4 Years

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) James R Bean M. D.

2 8 29 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Ida	Feb. 26 1929

20. Undertaker P. L. Stacy Address Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

65137

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MAR 27 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65137

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 11
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Willard A Hall.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Edith ~~Wayne~~ Wayne Hall.

6. DATE OF BIRTH (month, day and year): Feb 28 1893

7. AGE: Years 36 | Months | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Auto Mechanic.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho.

PARENTS
10. NAME OF FATHER: G. E. Hall.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Michigan.
12. MAIDEN NAME OF MOTHER: Jannie Ball.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill.

14. Informant: Elsie Hall.
(Address): Payette Idaho.

15. Filed Mar 20, 1929. J. O. Woodward, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1928, to Mar. 18, 1929
that I last saw him alive on Mar. 18, 1929
and that death occurred, on the date stated above, at 9:30 P. m.
The CAUSE OF DEATH* was as follows:
Tuberculosis Pulmonary

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Sputum & Tray.
(Signed) Marvin R Fox, M. D.
Mar. 19, 1929 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Payette Idaho. | Date of Burial: Mar 20 1929

20. Undertaker: Glenn C Landon. | Address: Payette Ida.

6 5137

GLENN C. LANDON
FUNERAL DIRECTOR AND LICENSED EMBALMER
PAYETTE, IDAHO

Payette Idaho.
Oct-18-34.

State of Idaho.
Department of Public Welfare
Boise. Idaho.

Dear Sir:- Am returning the death certificate for the correction, Please change the spelling of Mrs Halls name to Edith Wayne Hall and return same to me.

Respectfully.
Glenn C. Landon.
Payette.
Idaho.

65138

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65138

Local Registrar's No. 55

Registration District No. 73
Primary Registration District No. 2150
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH
County of Bonneville
City of Idaho Falls, Ida.

2. FULL NAME Hoyt S. Wimer

(a) Residence. No. Ucon, Idaho. St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jessie Wimer

6. DATE OF BIRTH (month, day and year) Oct. 8, 1989

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
39	4	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Jasper, Iowa
(State or country)

PARENTS

10. NAME OF FATHER Sylvester Wimer
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Ohio
12. MAIDEN NAME OF MOTHER Barbara Moon
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Ohio

14. Informant Jessie Wimer
(Address) Idaho Falls, Idaho.

15. Filed Mar 6, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 7, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Accidental traumatism by being cought in electric driven water pump jack.
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) B.J. Allen - Coroner, M. D.
Mar. 8/29 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho	Mar. 10/ 1929

20. Undertaker J. J. McHam Address Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Dr. Parker RECEIVED APR 4 1929

(989) 65139

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65139

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 109

(No. 1122 Michigan St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Louisa Southwick.

(a) Residence. No. 1122 Michigan St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Bert Southwick.

6. DATE OF BIRTH (month, day and year) Oct. 5th 1860

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
68	4	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Decater, Ind.

PARENTS

10. NAME OF FATHER: Arthur Patterson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Mary Fowler.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown.

14. Informant: Mrs. J. E. Reagan.
(Address) Boise, Idaho.

15. Filed 3/4/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 1st 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May, 1928, to Mar 1, 1929

that I last saw her alive on , 19

and that death occurred, on the date stated above, at 2:30P.M m.

The CAUSE OF DEATH* was as follows: Fortis Regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? 4

Did an operation precede death? No Date of --

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) D H Parker, M. D.

Mar 8, 1929 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery.

Date of Burial: 3/4/29 19

20. Undertaker: Wm. McBratney.

Address: Boise, Idaho.

...should state CAUSE OF DEATH in plain terms, so that it may be properly classified. ...TION is very important. See instruction on back of certificate.

Boise

65140

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65140

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 103

(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eugene F. Carver.

(a) Residence. No. Boise, Idaho. R. #4. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Carver.

6. DATE OF BIRTH (month, day and year): Oct. 16th 1868

7. AGE: 60 Years | Months: 5 | Days: 10 | If LESS than 1 day, ~~hrs.~~ or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Stock Man.

(b) General nature of industry, business, or establishment in which employed (or employer): Standard Furniture Co.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lake Mills, Wis.

PARENTS

10. NAME OF FATHER: T. C. Carver.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: L. Foote.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Don't Know.

14. Informant: Mrs. E. F. Carver.

(Address) Boise, Idaho. R. #4.

15. Filed 3/28/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 26th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Feb 10th, 1929, to March 26th, 1929 that I last saw him alive on March 26th, 1929 and that death occurred, on the date stated above, at 3 P.M m.

The CAUSE OF DEATH* was as follows: Endocarditis + Pulmonary abscesses (multiple) of left lung.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute inflammatory rheumatism (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Bouk, M. D.

3/27/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: 3/28/29 19

20. Undertaker: Wm. McBratney. | Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Pettengs 65141

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 8

DO NOT WRITE IN THIS SPACE
State File No. 6574

Registration District No. .....
Primary Registration District No. 2008
Local Registrar's No. 16

PLACE OF DEATH
County of Ada
City of Boise
(No.) Idaho Soldiers Home Hospital.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David Butler

(a) Residence. No. ..... Idaho Soldiers Home St.
(Usual place of abode)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1847

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
82			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Veteran of Civil
(b) General nature of industry, business, or establishment in which employed (or employer) War.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant E. G. Burnell
(Address) Idaho Soldiers Home Boise Ida

15. Filed 4/8, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 5 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1928 to April 5, 1929
that I last saw him alive on April 31, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Senility
..... (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocardial degeneration
..... (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms
(Signed) Fred A Ritter M. D.
4/6, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Apr 8 1929
20. Undertaker	Address
Summers & Krebs	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REC'D APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65142

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 104

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Gertrude L. Cruikshank.

(a) Residence. No. 1502 N. 13th St.
(Usual place of abode)
Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of John W. Cruikshank.

6. DATE OF BIRTH (month, day and year) July 7th 1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	8	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sheet Harbor, Nova Scotia.

PARENTS

10. NAME OF FATHER Alexander Fraser.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nova Scotia.
12. MAIDEN NAME OF MOTHER Lucy Behie.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nova Scotia.

14. Informant Fraser Cruikshank.
(Address) Klamath Falls, Oregon.

15. Filed 3/27/ 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25, 1929, to March 26, 1929
that I last saw her alive on March 25, 1929
and that death occurred, on the date stated above, at 8:40 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. A. Dorland, M. D.
3/27/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Truro, Nova Scotia.	19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65144

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 100

(No. U.S.Veterans' Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Karl F. Nelson

(a) Residence. No. Box 11 St. Kellogg, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. x yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 12, 1892

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
36	11	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant D.W.Herron

(Address) U.S.V.Hospital, Boise, Idaho

15. Filed 3/29/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 27, 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug.20,1929, 19, to Mar.27,1929, 19

that I last saw him alive on Mar.27,1929, 19

and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

Mar.28,1929, 19 (Address) MEDICAL OFFICER I U. S. VETERANS' HOSPITAL BOISE, IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg, Idaho

Date of Burial: 19

20. Undertaker: W.McBratney

Address: Boise, Idaho

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65145

PLACE OF DEATH

County of ~~Canyon~~ Ada.

City of ~~Nampa~~ Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 99

(No. StLukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Dorothea Henne

(a) Residence. No. Nampa, Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Matt Henne

6. DATE OF BIRTH (month, day and year): Apr 19, 1888

7. AGE: 40 Years | Months | Days | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ritter, Ore

PARENTS

10. NAME OF FATHER: Henry Fedler

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Catherine Schroeder

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Matt Henne
(Address) Nampa Route 3

15. Filed 3/20/, 1929 Paula McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7th, 1929, to March 27th, 1929, that I last saw her alive on March 27th, 1929, and that death occurred, on the date stated above, at 3:00 P m.

The CAUSE OF DEATH* was as follows:

Thyrotoxicosis
(Thyrotoxicosis)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Surgical parotitis R.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No contracted

Did an operation precede death? Yes Date of 3-22-29

Was there an autopsy? No

What test confirmed diagnosis? Physical & laboratory findings

(Signed) J. L. Stewart, M. D.

4-2, 1929, (Address) by L. F. West M.D. Boise Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cemetery
Date of Burial: 3/31 1929

20. Undertaker: Fred K. Robinson
Address:

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65146

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 4904
Local Registrar's No. 97
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arlando Charles Baird

(a) Residence. No. 5 Miles West of Boise St.
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Maude O. Baird

6. DATE OF BIRTH (month, day and year) March 1-1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	61	0	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Carrol Baird
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Arkansas
12. MAIDEN NAME OF MOTHER Sirpta Taylor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs Maude O. Baird
(Address) 1210 Franklin St Boise Ida

15. Filed 3/28/ 19 29 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to March, 1929
that I last saw h[illegible] alive on March 26, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Pernicious anaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Leo Collard, M. D.
3-28-, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	May 28 1929
20. Undertaker	Address
Summers & Krebs	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65147

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 96

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gertrude Brisbane Miller

(a) Residence. No. 1515 Grant St.
(Usual place of abode)
Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jules Miller

6. DATE OF BIRTH (month, day and year) Feb 7 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	1	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) South Carolina
(State or country)

PARENTS

10. NAME OF FATHER Benjamin J. Brisbane
11. BIRTHPLACE OF FATHER (city or town) South Carolina
(State or Country)
12. MAIDEN NAME OF MOTHER Sarah E. Dickson
13. BIRTHPLACE OF MOTHER (city or town) Penn
(State or Country)

14. Informant Jules Miller
(Address) 1515 Grant St. Boise Idaho

15. Filed 3/31, 1929 Paula M. Doan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31, 1929, to Mar 21, 1929
that I last saw her alive on Mar 20 9 P.M., 1929
and that death occurred, on the date stated above, at 8.40 m.

The CAUSE OF DEATH* was as follows:
Melanotic Sarcoma of
stomach & liver
original site breast & axilla.
(duration) 4 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical & microscopic
(Signed) H. M. Hobbson, M. D.
Mar 24, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery — Date of Burial March 23 1929
20. Undertaker Summers & Krebs. — Address Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

West.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 2

DO NOT WRITE IN THIS SPACE
State File No. 65148

Registration District No. 1004
Primary Registration District No. 1004
Local Registrar's No. 95

PLACE OF DEATH
County of Ada
City of Boise
(No. 1913 Washington St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Virginia Clenerley

(a) Residence. No. 1913 Washington St.
(Usual place of abode)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 19 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	10	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER David Souder
11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia
12. MAIDEN NAME OF MOTHER Matilda Hunsiger
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Gilbert Clenerley
(Address) Boise Idaho

15. Filed 4/4/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from September, 1927, to Death, 19
that I last saw h[illegible] alive on March 31, 1929
and that death occurred, on the date stated above, at 7:00 P. m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? Not contracted
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Physical findings

(Signed) Lyman F. West, M. D.
April 2, 1929 (Address) 413 Eastman Bldg Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	April 3 1929
20. Undertaker	Address
Summers & Wade	Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65149

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 92
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marie Rose Tessinger

(a) Residence. No. 1003 Vermont St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 3 1859

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	12.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) France.

PARENTS

10. NAME OF FATHER Marie Boulanger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) France
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Edward F Tessinger
(Address) 1808 Euclid ave, Boise Ida

15. Filed 3/18/, 1929 Paula McDonnell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-15-, 1929, to 3-15-, 1929
that I last saw her alive on 3-15-, 1929
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Booth, M. D.
3-16-, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Johns Cemetery	March 18 1929
20. Undertaker	Address
Summers & Krebs	Boise Idaho

RECEIVED APR 9 1929

S____ OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65150

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 91

2. FULL NAME Lucy Ann Mead
(a) Residence. No. 1612½ N 5 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Chris B Mead

6. DATE OF BIRTH (month, day and year): April-22-1860

7. AGE: 68 Years, 11 Months, 7 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kentucky

PARENTS
10. NAME OF FATHER: John M Clark
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Emma Cunningham
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tennessee

14. Informant: Chris B Mead
(Address) 1612½ N 5 St Boise Idaho

15. Filed 4/1/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 7, 1929, to Mar 29, 1929
that I last saw her alive on Mar 29, 1929
and that death occurred, on the date stated above, at 2 30 p m.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach
(duration) ..... yrs. 4 mos. ..... ds.
CONTRIBUTORY (Secondary) ——
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No (refused)
What test confirmed diagnosis?
(Signed) A B Bosch, M. D.
Mar 30, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: April 1 1929
20. Undertaker: Summers & Krebs — Address: Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65151

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 211 Wash. St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 90

2. FULL NAME Joseph Herfurth
(a) Residence. No. 211 Wash. St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 39 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelia Herfurth

6. DATE OF BIRTH (month, day and year) June 9 - 1857

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Second Hand Store
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) California Moniteau Co - Mo.

PARENTS

10. NAME OF FATHER Charles August Herfurth
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Saxony Germany
12. MAIDEN NAME OF MOTHER Catherine Walterschid
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Prussia Germany

14. Informant Stella M. Atkinson
(Address) 1303 N. 24th St Boise Idaho

15. Filed 3/26, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20, 1929, to Mar 20, 1929
that I last saw h. alive on Mar 20, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Coronary Heart Lesion
(duration) ? yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) O. N. Parker, M. D.
, 19 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Johns Cemetery	3/26 1929
20. Undertaker	Address
Schneider & McCann	Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Dr. Braxton

RECEIVED APR 9 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65152

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 89

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Jennie Moore.

(a) Residence. No. 518 State Street. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Madison Moore.

6. DATE OF BIRTH (month, day and year): April 6th 1849

7. AGE: 79 Years | Months: 11 | Days: 9 | If LESS than 1 day, ~~hrs. or~~ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Wisconsin.

PARENTS

10. NAME OF FATHER: Unknown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Mrs. A. A. Johnston.
(Address) Boise, Idaho.

15. Filed 3/15/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 15th 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended, deceased from Mar 6, 1929, to Mar 15, 1929 that I last saw her alive on Mar 14, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? Boise Idaho

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) T. N. Braxton, M. D.

3/15/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Portland, Oregon. | Date of Burial 19

20. Undertaker: Wm. McBratney. | Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 9 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65153

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 88

(No. St. Luke's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas R Haskin

(a) Residence. No. 111 E Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 18, 1852.

7. AGE	Years	Months	Days	If LESS than 1 day,
	76	6	11	hrs. or min.

8. OCCUPATION OF DECEASED:
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: H. Haskin
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs. H. M. Quick
(Address) 111 East Idaho St. Boise Ida

15. Filed 3/19/, 1929 Paula M. Donald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Feb 3, 1929, to Mar 19, 1929
that I last saw h[illegible] alive on Mar 19 1929
and that death occurred, on the date stated above, at 9 9 m.

The CAUSE OF DEATH* was as follows:
Senility
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible], M. D.
Mar 19, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Mar 20 1929

20. Undertaker: Summers & Krebs Boise Idaho
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65154

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 87

(No. Pacific Hotel.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Archie Clark.

(a) Residence. No. Pacific Hotel. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 19 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced, (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE: About 60 Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: COOK.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Pearl Allen.
(Address) Boise, Idaho.

15. Filed 3/9/, 1929 Paula McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 2nd 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~19~~ ~~to~~ ~~19~~ ~~that I last saw him alive on~~ ~~19~~ ~~and that~~ death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:
Found Dead in his room at Pacific Hotel. Natural Cause. From all appearances apoplexy was probably the cause. No Inquest held.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No. —

What test confirmed diagnosis? —

(Signed) W. McBratney, Coroner, ~~M. D.~~

3/6/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery.

Date of Burial: 3/6/29 19

20. Undertaker: Wm. McBratney.

Address: Boise, Idaho.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65155

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 84

2. FULL NAME Betty Louise Haynes
(a) Residence. No. 7 Miles N W of Boise St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April-16-1928

7. AGE Years Months 10 Days 27 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho,

PARENTS
10. NAME OF FATHER Benjamin F Haynes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Maud E. Cummings
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas,

14. Informant B F Haynes
(Address) Boise Idaho R U #1

15. Filed 3/14/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12, 1929, to Mar. 13, 1929
that I last saw her alive on Mar. 13, 1929
and that death occurred, on the date stated above, at 4:30 P. m.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cold

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) M. Calloway-Japlin, M. D.
Mar 14, 1929 (Address) Boise Idaho,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial Mar 15 1929

20. Undertaker Summers & Krebs
Address Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65156

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 83
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Walter Bates
(a) Residence. No. 1415 N 8 street St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Oct 10 1884
7. AGE: Years 44 | Months 4 | Days 26 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Civil Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Salt Lake Utah

PARENTS
10. NAME OF FATHER: Thomas Walter Bates
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maine
12. MAIDEN NAME OF MOTHER: Caddie Hardy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salt Lake Utah

14. Informant: Mrs Thomas W Bates
(Address) 1415 N 8 Street Boise Idaho
15. Filed 3/13/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1929, to March 6, 1929
that I last saw him alive on March, 1929
and that death occurred, on the date stated above, at 10.50 P. m.
The CAUSE OF DEATH* was as follows:
Ruptured Ulcer of stomach
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
Peritonitis (duration) yrs. mos. 5 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Feb.
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Harold W Lowe, M. D.
3/8, 1929 (Address) 317 Eastman Bldg Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pioneer Cemetery — Date of Burial: Mar 10 1929
20. Undertaker: Summers & Pope — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65157

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 82

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lodema Luella McMillen

(a) Residence. No. 111 Jefferson St. St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct-19-1850

7. AGE Years 78 Months 4 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Horace Taber

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Malenda Dawling

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant W. T. Phelps

(Address) 111 Jefferson St Boise Idaho

15. Filed 3/12/ 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 10 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/5, 1929, to 3/10, 1929

that I last saw her alive on 3/10, 1929

and that death occurred, on the date stated above, at 12,30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Emolis

Hemiplegia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Fred. A. Pettingill, M. D.

3/11, 1929 (Address) Boise Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery

Date of Burial: Mar 12 1929

20. Undertaker: Summers & Krets

Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65158

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 87
(No. U.S.Veterans' Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nels T. Liberg

(a) Residence. No. ..... St. Genesee, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. X yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. N. T. Liberg

6. DATE OF BIRTH (month, day and year) July 7, 1890

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	6	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Grain elevator worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Lars Liberg (deceased)
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Hanna Nelson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant D.W.Herron
(Address) U.S.V.Hospital, Boise, Idaho

15. Filed 3/14, 1929 Paula M. Donaca
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 13, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1929, 19..., to Mar. 13, 1929, 19...
that I last saw him alive on Mar. 13, 1929, 19...
and that death occurred, on the date stated above, at 8:40 A. m.
The CAUSE OF DEATH* was as follows:
Ileus paralytic

unknown (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Dilatation cardiac, acute
XX (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? Yes Date of 3-8-29
Was there an autopsy? Yes
What test confirmed diagnosis? XX
(Signed) F. B. Brewer, M. D.
Mar. 14, 1929, 19... (Address) MEDICAL OFFICER IN CHARGE U.S. VETERANS' HOSPITAL BOISE, IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Genesee, Idaho	19

20. Undertaker	Address
W.McBratney	Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 19

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65159

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 86

(No. St Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isaac Van Winkle

(a) Residence. No. ..... St. Pioneerville, Ida

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 12 - 1873

7. AGE Years 55 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Garden Valley Ida

PARENTS

10. NAME OF FATHER George Van Winkle

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Missouri Naylor

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Nettie Van Winkle

(Address) Parma Idaho

15. Filed 3/6/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2, 1929, to March 4, 1929

that I last saw him alive on March 4, 19

and that death occurred, on the date stated above, at 2.45 A. m.

The CAUSE OF DEATH* was as follows:

~~Syphilis~~

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

4 7, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Garden Valley, Ida

Date of Burial 19

20. Undertaker Schreiber & McCann

Address Boise, Ida

Stewart

RECEIVED APR 3 1929

AFFIDAVIT FOR CHANGE OF CAUSE OF DEATH
IN DEATH CERTIFICATE

STATE OF IDAHO, :
ss
COUNTY OF ADA. :

Dr. George Collister, being first duly sworn says:

that he is a practicing Physician, duly licensed to practice medicine in the state of Idaho; and that he was on the 25th day of March~~ry~~, 1929 ~~and thereafter~~ practicing medicine within said state at Boise,Idaho; That he did on the 7th day of March 1929, make and sign a certificate of death for one Isaac Van Winkle, whose death occurred at St Alphonsus Hospital at Boise,Idaho, on the 5th day of March 1929, and that he by mistake made the entry of the cause of death in said certificate as "Syphilis" and that in truth and in fact the said Isaac Van Winkle died of ,and the cause of his death was Apoplexy

That the affiant desires that the said Death Certificate relating to Isaac Van Winkle be changed to read as the cause of death the following, Apoplexy instead of the statement therein contained namely, "Syphilis".

And further your affiant sayeth not.

Geo Collister

Subscribed and sworn to before me this 16th day of March, 1929.

Notary Public for Idaho,
Residence, Boise,Idaho.

RECEIVED APR

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65160

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2008
Local Registrar's No. 15
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Raymond C. Bienapfl
(a) Residence. No. 7 1/2 West of City Ada County
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) February 6 1929

7. AGE Years | Months 1 | Days 13 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Alphonsus Hospital

PARENTS
10. NAME OF FATHER Raymond W. Bienapfl
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boise, Ida
12. MAIDEN NAME OF MOTHER Emma Tetter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Boise,

14. Informant R. W. Bienapfl
(Address) R 1 4 Boise, Ida

15. Filed 3/18/ 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 17, 1929, to Mch 19, 1929
that I last saw him alive on Mch 18, 1929
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? yes
(Signed) Chas. V. Gemmy M. D.
Mch 20 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. John's Cemetery | Date of Burial 3/19 1929

20. Undertaker Schreiber & McCann | Address Boise, Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65161

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2008

Local Registrar's No. 14

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John F. Cecil

(a) Residence. ~~No.~~ Valley View Dist. Ada County
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 22-1904

7. AGE Years 19 Months 11 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Valley View, Ada Co

PARENTS

10. NAME OF FATHER John Cecil

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill

12. MAIDEN NAME OF MOTHER Ida Wortman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs Ida Cecil.
(Address) Boise, Ida

15. Filed 3/16/, 1929 Paula McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/9 29, 19..., to only, 19...
that I last saw him alive on 3/9, 1929
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Complications
Lobar Pneumonia
Cerebral Hemorrhage.
(duration) ✓ yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. J. Coats, M. D.

....., 19.... (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Joplin Cemetery — Date of Burial 3/17 1929

20. Undertaker Schreiber & McCann — Address Boise, Ida

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65162

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 12008
Local Registrar's No. 12
(No. Idaho Soldiers Home
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Thomas Kingsbury.
(a) Residence. No. Idaho Soldiers Home St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 15 1869

7. AGE 59. Years Months 6 Days 13. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS
10. NAME OF FATHER Thomas Kingsbury
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Elizabeth Wales
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs. Willigin Rember.
(Address) Hailey Idaho. Box 503

15. Filed 4/2, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar - 28 - 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19 , to , 19~~
~~that I last saw h alive on , 19~~
~~and that~~ death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Found Dead. Natural Cause.
Had only been dead about half an hour when found.
Had Chronic heart trouble and this was Cause of Death for what I can find out.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
No Inquest was held, ds.
(duration) yrs. mos.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? - No -
What test confirmed diagnosis?
(Signed) C. McMahey - Coroner, M. D.
3/29/29. 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial Mar. 30 1929

20. Undertaker Summers & Krebs
Address Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65163

PLACE OF DEATH

County of Ada

City of Boise, Idaho

Registration District No. 8

Primary Registration District No. 2008

Local Registrar's No. 13

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rose E. Basil James.

(a) Residence. No. 503 Jefferson St. Garden Valley, Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Fred D. James

6. DATE OF BIRTH (month, day and year) June 22, 1863.

7. AGE: 65 Years | Months: 9 | Days: 6 | If LESS than 1 day, 6 hrs. and or 45 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: Nelson R. Basil

11. BIRTHPLACE OF FATHER (city or town) (State or Country):

12. MAIDEN NAME OF MOTHER: Mary Miles

13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Fred D. James.

(Address) Garden Valley, Idaho.

15. Filed 3/29, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929, to Mar 29, 1929

that I last saw her alive on Mar 28, 1929

and that death occurred, on the date stated above, at about 9 a.m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia & Myocardial failure. Metastatic Carcinoma of Lung (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) ↗

(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Xray Spitzer

(Signed) M. J. Mendeling, M. D.

3/29, 1929 (Address) Boise, Ida. (Mendeling)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pioneer Cemetery | Date of Burial: 3/29 1929

20. Undertaker: Schreiber & McCann | Address: Boise, Ida

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65164

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2008
Local Registrar's No. 11
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Georgana M Robertson
(a) Residence. No. 3 Miles East of Star
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of W. A Robertson
6. DATE OF BIRTH (month, day and year) Jan. 17-1879
7. AGE Years 50 Months 1 Days 24 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ogden Utah
PARENTS
10. NAME OF FATHER Charles D. Tyrie
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Isella Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin
14. Informant W. A Robertson
(Address) Eagle Idaho RD#1
15. Filed 3/13, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 11 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 5 years, 19..., to Mar 11, 1929
that I last saw her alive on Mar 11, 1929
and that death occurred, on the date stated above, at 12-10 P m.
The CAUSE OF DEATH* was as follows:
Cardiac Dropsy —
Collapse of Heart
& many complications
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Mastoid disease
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) [illegible] M. D.
Mar 12, 1929 (Address) Star Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial Mar 15 1929
20. Undertaker Summers & Krebs
Address Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65166

PLACE OF DEATH
County of Ada
City of Meridian

Registration District No. 11
Primary Registration District No. 2003
(No.)
Local Registrar's No. 3

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alice Isadora Hartman

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chas. Hartman.

6. DATE OF BIRTH (month, day and year) Oct 10, 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	75	5	14	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife (retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wilmington Ohio

PARENTS

10. NAME OF FATHER John Patton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Helen Tomlin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know Ohio

14. Informant Mrs Lant Hartman
(Address) Meridian, Ida

15. Filed 3-26, 1929 J F Neal
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/18, 1927 to 12-12-, 1928
that I last saw h-r alive on 12-12, 1928
and that death occurred, on the date stated above, at 7.30 P.M.
The CAUSE OF DEATH* was as follows:
Bright's disease
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J F Neal, M. D.
3-26, 1929 (Address) Meridian

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Ida	3/27 1929
20. Undertaker B W Robison	Address Meridian Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65168

PLACE OF DEATH MAR 15 1929

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5502

(No. Lynn Bras Kunt Hospital

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jacob Inman

(a) Residence. No. Challis Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Single widowed

6. DATE OF BIRTH (month, day and year)

7. AGE: 78 Years | Months: 2 | Days: — | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

(c) Name of employer: Self

9. BIRTHPLACE (city or town) (State or country): unknown

PARENTS

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: McLain

(Address) Pocatello Idaho

15. Filed 7/12, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21, 1929, to Feb 12, 1929

that I last saw him alive on Feb 12, 1929

and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary): age

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Challis Idaho

Did an operation precede death? yes Date of Feb 4-29

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) M. C. Lynn, M. D.

7/12/29 19.. (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mackey Idaho | Date of Burial: 2-14 1929

20. Undertaker: Schumacher & Beasley | Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 15 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Howard

DO NOT WRITE IN THIS SPACE

State File No. 65169

Local Registrar's No. 5503

2. FULL NAME Mary Daunila

(a) Residence. No. 225 So Sixth St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE Mexican

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 14 Years Months Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mexico

PARENTS

10. NAME OF FATHER Presilions Desnila

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico

12. MAIDEN NAME OF MOTHER Presilion Dounila

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Presilions Daunella

(Address) Pocatello Idaho

15. Filed 2/13, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1929, to Feb. 12, 1929

that I last saw her alive on Feb. 11, 1929

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows: Valvular Heart Disease

(duration) yrs. few mos. ds.

CONTRIBUTORY (Secondary) Ruptured Compensation

(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. F. Howard M. D.

2/13, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt View Cemetery Date of Burial 2/14/29

20. Undertaker H. R. McCann Address Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65170

RECEIVED MAR 15 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5504

(No. 1803 So. 2nd ave.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bert Edward Smith.

(a) Residence. No. 1803 So. 2nd ave St

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) July 30, 1928

7. AGE — Years | 6. Months | 14 Days | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Ida.

PARENTS

10. NAME OF FATHER Samuel E. Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Dorothy Perky

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pocatello Ida.

14. Informant Samuel E. Smith

(Address) Pocatello Ida.

15. Filed Feb 13, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-10, 1929, to 2-13, 1929

that I last saw her alive on 2-12, 1929

and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Pneumonia broncho.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm Brothers M. D.

Feb 13, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Ida | Date of Burial: Feb 15 1929

20. Undertaker: McHan Undt Co. | Address: Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65171

RECEIVED MAR 15 1929

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5505
(No.) Pocatello General Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Junior Marimato

(a) Residence. No. ... St. ...
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Japanese
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 17 - 28

7. AGE: Years | Months: 6 | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS

10. NAME OF FATHER K. Marimato
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan
12. MAIDEN NAME OF MOTHER Uchiyama
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Japan

14. Informant K. Marimato
(Address) Tyhee Idaho

15. Filed 2/16, 1929 J. P. Manny Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1929, to Feb. 14, 1929
that I last saw h[illegible] alive on Feb. 14 1929
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(duration) ... yrs. ... mos. 5 ds.
CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) W. F. Howard M. D.
2/15, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View Cemetery	2/16/29
20. Undertaker	Address
D. L. McHaw	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH RECEIVED MAR 15 1929

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65172

County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5506
(No. 435 WEST DAY)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John T Brower

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ JOSEPHINE WORKMAN

6. DATE OF BIRTH (month, day and year) DECEMBER 13 1852

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	2	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work RETIRED
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) SALT LAKE UTAH

PARENTS

10. NAME OF FATHER ARIAH C. BROWER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....
12. MAIDEN NAME OF MOTHER ELIZABETH HUSSEY
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant GEORGE H. BROWER
(Address) POCATELLO IDAHO

15. Filed 3/16, 1929 J. M. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH FEBRUARY 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended ~~deceased~~ from Feb 10, 1929, to Feb 14, 1929, that I last saw h~~im~~er alive on Feb 12, 1929 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Apoplexy
..... (duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) General Arteris Sclerosis
..... (duration) 7 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Supp Expanse Co
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) O. G. Read, M. D.
3/13, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
LEWISTON UTAH	19
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65173

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5508
(No. 139 So 11th St)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucy Hoult

(a) Residence. No. 139 So 11th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, ~~widowed, or divorced~~
~~HUSBAND~~ of
(~~or~~) WIFE of Wm Hoult

6. DATE OF BIRTH (month, day and year) July 26th 1852

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	6	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Spraster
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Arthur Hoult
(Address) 139 So 11th Pocatello Ida

15. Filed 2/20, 1929 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16, 1928, to Feb 16, 1929
that I last saw her alive on Feb 16, 1929
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John J Rost M. D.
2-16, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View Cemetery	2/19th 1929
20. Undertaker	Address
Schumacher & Beasley	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65174

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5510

(No. 724 NORTH 9TH AVENUE)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ELVIN LEROY LISH

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. ..... mos. 21 ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) NOVEMBER 18 1928

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	3	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work INFANT

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) PORTNEUF, IDAHO

PARENTS

10. NAME OF FATHER ELVIN N. LISH

11. BIRTHPLACE OF FATHER (city or town) (State or Country) McCAMMON IDAHO

12. MAIDEN NAME OF MOTHER CLARISSA ROBINSON

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) MEXICO

14. Informant ELVIN N. LISH

(Address) 724 N. 9TH AVE.

15. Filed 7/22, 1929 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH FEBRUARY 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/20, 1929, to 7/20, 1929 that I last saw him alive on Dead 7/20, 1929 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) malnutrition

Since Birth (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? History

(Signed) F. H. Lyon, M. D.

7/21/29 19.... (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
McCAMMON IDAHO	
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65175

RECEIVED MAR 15 1929

PLACE OF DEATH
County of BANNOCK
City of POCATELLO
FOUND IN POCATELLO FEB. 20, 1929

Registration District No. 28
Primary Registration District No. 2161
(No. P.F.E.R.R. CAR No. 3609 ENROUTE)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5511
EXACT PLACE OF DEATH UNKNOWN

2. FULL NAME JOHN O'NEIL
(a) Residence. No. COUNCIL BLUFFS, IOWA St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): SINGLE

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) OCT. 14, 1892.

7. AGE: Years 36 | Months 3 | Days BETWEEN 19 + 30 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work SWITCHMAN
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) CHEROKEE IOWA.

PARENTS

10. NAME OF FATHER FRANK O'NEIL
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ILLINOIS
12. MAIDEN NAME OF MOTHER ELLEN SULLIVAN
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) NEW YORK

14. Informant ARTHUR O'NEIL
(Address) COUNCIL BLUFFS, IOWA.

15. Filed 4/23, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH EXACT DATE UNKNOWN SOMETIME BET. FEB. 7 + 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ___, 19___, to ___, 19___
that I last saw h___ alive on ___, 19___
and that death occurred, on the date stated above, at ___ m.
The CAUSE OF DEATH* was as follows:
asphyxiated by carbon dioxide Gas from charcoal in bunker of P.F.E. car accidental
(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)
(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Arthur W Hall Coroner, ~~M. D.~~
Feb 23, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: COUNCIL BLUFFS IOWA
Date of Burial: ON ARRIVAL 19

20. Undertaker: ARTHUR W. HALL
Address: POCA, IDA.

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65176

Local Registrar's No. 5512

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

Registration District No. 28

Primary Registration District No. 2161

(No. COUNTRY CLUB)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME MARRITT EARL THATCHER

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: [redacted]

4. COLOR OR RACE: WHITE

5. Single, Married, Widowed, or Divorced (write the word): INFANT

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) OCT. 21 1928

7. AGE — Years: 0 — Months: 4 — Days: 7 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: INFANT

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): POCATELLO IDA.

PARENTS

10. NAME OF FATHER: JOHN HARRIS THATCHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country): CHICAGO

12. MAIDEN NAME OF MOTHER: ZINA PALMER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): IDAHO

14. Informant: MR. JOHN H THATCHER

(Address): POCATELLO, IDAHO.

15. Filed 3/28, 1929 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: FEBRUARY 28 (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...

that I last saw h... alive on ....., 19...

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Got smothered by cat found sleeping on Babies face and died

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Arthur W. Hall. Coroner M. D.

3/28, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW	MARCH. 2 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO IDAHO.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65177

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5573
(No. 310 So 11th ave)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Moroni Sherwood
(a) Residence. No. 310 So 11th ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 26th 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	Still Born			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Ida

PARENTS

10. NAME OF FATHER Moroni Sherwood
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden Utah
12. MAIDEN NAME OF MOTHER Pearl Kate Dyl
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant M Sherwood
(Address) 310 So 11th ave

15. Filed 3/4, 1929 J H Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-25, 1929, to 2-26, 1929
that I last saw him alive on 2-26, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

premature birth 6 1/2 hrs.
due to influenza in
mother (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) D C Ray M. D.
3-2, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	2-28 1929
20. Undertaker	Address
Schumacher & Beasley	City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

16258 N

Miller.

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65178

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5514

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Molly Chocon
(a) Residence. No. 223 So Second St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE Mexican
5. Single, Married, Widowed, or Divorced (write the word) —
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) Aug 14th 1928
7. AGE Years Months 7 Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS
10. NAME OF FATHER Maurice Chocon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) U.S.A.
12. MAIDEN NAME OF MOTHER Poblita Mahan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Colorado

14. Informant Maurice Chocon
(Address) Pocatello Idaho

15. Filed 3/4, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 3rd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to Mch 3, 1929
that I last saw her alive on Mch. 1929
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F. S. Miller, M. D.
3/4, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt View Cem Date of Burial 3/4/29 19
20. Undertaker H. L. McHan Address Pocatello Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65179

PLACE OF DEATH
County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 2161
(No. O.S.L. DEPOT)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 5515

2. FULL NAME CHARLES ROGERS

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	UNKNOWN

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
ABOUT 65	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work UNKNOWN
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) UNKNOWN

PARENTS
10. NAME OF FATHER UNKNOWN
11. BIRTHPLACE OF FATHER (city or town) (State or Country) UNKNOWN
12. MAIDEN NAME OF MOTHER UNKNOWN
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UNKNOWN

14. Informant John McMillan
(Address) Superior Montana

15. Filed 3/7, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MARCH (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-6, 1929, to 3-6, 1929
that I last saw h~~im~~ alive on 3-6, 1929
and that death occurred, on the date stated above, at 6 ~~P~~ m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris Sudden
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis?
(Signed) W. W. Brothers M. D.
3-7, 1929 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Superior Mont	
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65180

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Poc. General Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5516

2. FULL NAME Theodore Anderson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): March 27, 1908

7. AGE: Years 20, Months 11, Days 14. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Colorado.

PARENTS

10. NAME OF FATHER: John H. Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Anna Hansen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): U. S. A.

14. Informant: John H. Anderson
(Address): Gibson Idaho

15. Filed 3/9, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 8 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12 M Mch 8, 1929, to 8 pm Mch 8, 1929 that I last saw him alive on 7 pm Mch 8, 1929 and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows: Cerebro-spinal meningitis

..... (duration) ..... yrs. ..... mos. 1 1/2 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Ft Hall Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical and Laboratory
(Signed) W. F. Howard M. D.
3/9, 1929 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Ida. Date of Burial: Mar 10 1929

20. Undertaker: McHan Undt Co. Address: Pocatello

RECEIVED MAR 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65181

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. 131 PARK AVENUE)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5517

2. FULL NAME JOSEPH BRYANT HAWKES

(a) Residence. No. 131 PARK AVENUE St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ ANNIE DOWDLE

6. DATE OF BIRTH (month, day and year) NOV. 5 1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	4	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work CARPENTER
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) SPANISH FORK. UTAH

PARENTS

10. NAME OF FATHER HAWKES
11. BIRTHPLACE OF FATHER (city or town) (State or Country) TENNESSEE
12. MAIDEN NAME OF MOTHER MARY LEWIS
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) WALES

14. Informant MRS J. B. HAWKES
(Address) 131 PARK AVENUE.

15. Filed 3/11, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MARCH (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1928, to MAR 9, 1929
that I last saw h~~im~~ alive on 3/9, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
~~Cancer~~ Carcinoma of Stomach
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Ulcer of Stomach
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? NO Date of —
Was there an autopsy? NO
What test confirmed diagnosis? clinical
(Signed) J. H. Young, M. D.
3/14, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello Ida	3/12 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65182

Local Registrar's No. 5518

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

Registration District No. 28

Primary Registration District No. 2161

(No. GENERAL HOSPITAL)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME PETER LARSEN

(a) Residence. No. 435 W. Clark St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ POULINE SWENSEN

6. DATE OF BIRTH (month, day and year) JULY 13 1851

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	77	7	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work LABORER

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) DENMARK

PARENTS

10. NAME OF FATHER LARS C NEILSEN

11. BIRTHPLACE OF FATHER (city or town) (State or Country) DENMARK

12. MAIDEN NAME OF MOTHER UNKNOWN

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) DENMARK

14. Informant MAE PETER LARSEN

(Address) 435 W. CLARK

15. Filed 3/11, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MARCH (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec, 1928, to Mar 9, 1929

that I last saw h____ alive on 3/9, 1929

and that death occurred, on the date stated above, at 6 10 a m.

The CAUSE OF DEATH* was as follows:

Cardio Renal disease

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted — if not at place of death?

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) J. H. Young, M. D.

3/11, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello Ida	3/12 1929
20. Undertaker	**Address**
ARTHUR W HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1929

FORM V. S. No. 6-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 83
Primary Registration District No. 2
File No. 65183
Registered No. 105

1. PLACE OF DEATH
County of Bannock
City of Arimo
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Harrison Tippetts
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 23 (Day) 1873 (Year)

7. AGE: 55 Yrs. 9 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Farmington, Utah.

10. NAME OF FATHER: John Bailey Tippetts

11. BIRTHPLACE OF FATHER (State or Country): Wilton, New Rockingham Co. Hampshire

12. MAIDEN NAME OF MOTHER: Eleanor Weir

13. BIRTHPLACE OF MOTHER (State or Country): Woodford England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. James H. Tippetts
(Address) Arimo Idaho

15. Filed Mar 12 1929 Mary C. Coffin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 19..., to ——— 19...,
that I last saw h... alive on ——— 19...,
and that death occurred on the date stated above, at 11½ A.M.
The CAUSE OF DEATH* was as follows: Sudden Death Probably Heart trouble
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. J. Barrington M. D.
2-9-1929 (Address) Downey, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arimo Idaho — DATE OF BURIAL: 2-11-1929

20. UNDERTAKER: — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED MAR 14 1929

1. PLACE OF DEATH
County of Bannock
City of Downey Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83
Primary Registration District No. 2160
(No. ..... St.)

File No. 65184
Registered No. 184
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bundie Mines

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: April (Month) 27 (Day) 1878 (Year)

7. AGE: 50 Yrs. 9 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Napa Calif.

10. NAME OF FATHER: Lee Roney

11. BIRTHPLACE OF FATHER (State or Country): Napa Calif.

12. MAIDEN NAME OF MOTHER: Martha Mecomt

13. BIRTHPLACE OF MOTHER (State or Country): Napa California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Effie Veirs
(Address) Napa California

15. Filed Mar 14 1929 Mary C. Coffin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 14 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... P.M.

The CAUSE OF DEATH* was as follows:
Probably Gastric hemorrhage. Found dead in bed pool of blood coming from mouth & nose.
(Duration) ? Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) H. H. Harrington M. D.
2-15 1929. (Address) Downey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Downey Ida. DATE OF BURIAL: Feb 19th 1929

20. UNDERTAKER: Fred Foster ADDRESS: Downey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 18 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8-9
Primary Registration District No. 2160
File No. 65185
Registered No. 109

1. PLACE OF DEATH
County of Bannock
City of Downey
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Joseph Wokley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: October 10 1866 (Month) (Day) (Year)

7. AGE: 62 Yrs. 4 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Willard, Utah

10. NAME OF FATHER: John N. Wokley

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Elenna Hemmway

13. BIRTHPLACE OF MOTHER (State or Country): New Hampshire

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L. J. Wokley
(Address) Downey Idaho

15. Filed Mar 14 1929 Mary B. Coffin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 12 1929. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1929 to Feb 12 1929 that I last saw him alive on Feb 12 1929 and that death occurred on the date stated above, at 4-25 P.M.

The CAUSE OF DEATH* was as follows: Bronchial Asthma Chronic.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Myocarditis & Nephritis
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) H. E. Hartwigsen M. D.
2-12-1929 (Address) Downey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Downey Idaho — DATE OF BURIAL: Feb 15 1929

20. UNDERTAKER: L. F. Woodland — ADDRESS: Inalad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 65186
Registered No. 3

1. PLACE OF DEATH
County of Bear Lake
City of St. Charles,
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Keetch Hymas

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: April (Month) 9 (Day) 1928 (Year)
7. AGE: ..... yrs. 10 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Delbert Price Hymas
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Theodosia Keetch
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Delbert Hymas
(Address) St. Charles, Idaho.
15.
Filed Mar 14 1929 Hannah J. Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 8 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 6 1929 to Mar 8 1929
that I last saw him alive on Mar 8 1929
and that death occurred on the date stated above, at 2.30 P M.
The CAUSE OF DEATH* was as follows:
Pneumonia, Tobacco
.....
.....
(Duration) ..... yrs. ..... mos. 8 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C O Nevon M. D.
Mar 9 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: .....
DATE OF BURIAL: Mar. 11 1929

20. UNDERTAKER: .....
ADDRESS: .....

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18872

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65187

RECEIVED APR 11 1929

PLACE OF DEATH
County of Bear Lake
City of St. Charles

Registration District No. 55
Primary Registration District No. 2134
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

2. FULL NAME Lorenzo Dow Young
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 24, 1854

7. AGE: 74 Years | Months: 11 | Days: 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Salt Lake City

PARENTS

10. NAME OF FATHER: Wm G. Young
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Adelia Clark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New York

14. Informant X Ethel Wilhelmsen
(Address)

15. Filed ....., 19.... Hannah J. Nelson a.m. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11, 1929, to Mar 18, 1929
that I last saw him alive on Mar 12, 1929
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:
Cardio-Vascular-Renal Disease
..... (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) C O Moore, M. D.
3/21, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial: Mar. 21 1929

20. Undertaker | Address

RECEIVED APR 1 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65188

PLACE OF DEATH
County of Bear Lake
City of Bloomington
Registration District No. 5-3
Primary Registration District No.
Local Registrar's No. 119
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Bull Wilks

(a) Residence. No. / Bloomington Ida St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Fred Wilks

6. DATE OF BIRTH (month, day and year): Nov 4, 1841

7. AGE: Years 87 | Months 4 | Days 21 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: John Bull
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Mary Turner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: John Wilks
(Address) Paris Idaho

15. Filed 3-30, 1929 Mrs. J. S. Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Feb~~ Mar 25, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25, 1929, to Mar 25, 1929
that I last saw her alive on Feb 25, 1929
and that death occurred, on the date stated above, at 4.30 a. m.
The CAUSE OF DEATH* was as follows:
Pneumonia, Hypostatic

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) C O Moore M. D.
3/26, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bloomington Idaho
Date of Burial: 3-27 1929
20. Undertaker: John Hulme
Address: Bloomington Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 1 1929

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 65189

1. PLACE OF DEATH.
County of Bear Lake
City of Liberty
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 53
Primary Registration District No.
(No. , St.)

Registered No. 118
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mont Hymas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Sept. 9 (Month) 9 (Day) 1919 (Year)

7. AGE: 9 yrs. 6 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Bear Lake, Idaho.

10. NAME OF FATHER: James A. Hymas

11. BIRTHPLACE OF FATHER (State or Country): Utah,

12. MAIDEN NAME OF MOTHER: Elva Matthews

13. BIRTHPLACE OF MOTHER (State or Country): Bear Lake, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ast Matthews
(Address) Liberty Idaho.

15.
Filed 3-20 1929 Mrs. J. S. Skinner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1929, to Mar 16 1929 that I last saw him alive on Mar 13 1929 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis
(Duration) ..... yrs. 2 mos. ..... ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 10 ds.
(Signed) C O Moore M. D.
3/18 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Liberty Idaho
DATE OF BURIAL: 3-18 1929

20. UNDERTAKER: T. L. Austin
ADDRESS: Liberty Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

RECEIVED APR 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65190

PLACE OF DEATH

County of Bennah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 6

(No. Espe Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace Irene McAlinden

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 5 - 1927

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	9	18	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) St Maries
(State or country) Ida.

PARENTS

10. NAME OF FATHER Edward Ludwick McAlinden
11. BIRTHPLACE OF FATHER (city or town) Duluth
(State or Country) Minn.
12. MAIDEN NAME OF MOTHER Lillian Marie Tookey
13. BIRTHPLACE OF MOTHER (city or town) Winona
(State or Country) Minn.

14. Informant John McAlinden
(Address) Emida Ida.

15. Filed Mar 14, 1929 O Illegible
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
3/12, 1929, to 3/13, 1929
that I last saw h- alive on 3/13, 1929
and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:
Meningitis (Simple)
Flu
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza & Pneumonia
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) G V Espe, M. D.
3/14, 1929 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Woodlawn	May 15 1929
20. Undertaker	**Address**
Mitchell & Meagher	St Maries Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65191

PLACE OF DEATH
County of Benewah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049
(No. St Maries Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number)

Local Registrar's No. 7

2. FULL NAME Elmer Grandlund (or Granlund)

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): ?

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6. DATE OF BIRTH (month, day and year) Jan 3 - 1896

7. AGE: Years 33, Months 2, Days 27. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer): Logging
(c) Name of employer: Blackwell Lumber Co, Emida, Ida

9. BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS

10. NAME OF FATHER: not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): not known
12. MAIDEN NAME OF MOTHER: not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): not known

14. Informant: St Maries Hosp
(Address) St Maries Ida

15. Filed Mar 30, 1929 O. Meraguer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 13, 1929, to Mar 30, 1929
that I last saw him alive on Mar 30, 1929
and that death occurred, on the date stated above, at 11 3/4 a. m.
The CAUSE OF DEATH* was as follows:
Acute Endocarditis
..... (duration) ..... yrs. ..... mos. 15 ds.
CONTRIBUTORY (Secondary) Influenza
..... (duration) ..... yrs. 1 mos. ..... ds.

18. Where was disease contracted if not at place of death? Not known
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Clinical.
(Signed) Catogins, M. D.
Apr 1, 1929 (Address) St Maries, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Blair Wise — Date of Burial: Apr 3 1929

20. Undertaker: Mitchell & Meraguer — Address: St Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17

RECEIVED APR 11 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 65192
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 46
Primary Registration District No. 2133
(No. ....., ... St.)

1. PLACE OF DEATH
County of Bonneville
City of Shoshone
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Erwin Taylor

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) Jan. (Day) 11 (Year) 1916

7. AGE: 12 Yrs. 11 Mos. 3 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chas E. Taylor

11. BIRTHPLACE OF FATHER (State or Country): Chicago

12. MAIDEN NAME OF MOTHER: Gertrude B. Moody

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gertrude B. Taylor
(Address) Plummer, Idaho

15. Filed Jan. 17 1929 — B. Jaeger, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Jan. (Day) 8 (Year) 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan. 7 1929 to Jan 7 1929
that I last saw h~~e~~r alive on Jan. 7 1929
and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:

Anemia and Flu.

.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) L. J. Harrington M. D.
1/9 1929 (Address) Wardner, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Plummer, Ida — DATE OF BURIAL: Jan. 9 1929

20. UNDERTAKER: B. Jaeger — ADDRESS: Plummer Ida.

RECEIVED MAR 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65193

PLACE OF DEATH
County of Benewah
City of Near St. Joe Ida
Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 5
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wanny Elizabeth Reid
(a) Residence. No. [redacted] St. Joe Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 38 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Albert D Reid
6. DATE OF BIRTH (month, day and year) July 8
7. AGE Years 65 Months 6 Days 25 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmers wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Cambridge Ohio

PARENTS
10. NAME OF FATHER James Wormock
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cambridge Ohio
12. MAIDEN NAME OF MOTHER Sara Jane Edwards
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Cambridge Ohio

14. Informant Mrs. A. D. Reid
(Address) St. Joe Idaho.
15. Filed Feb 4, 1929 O Clemenger Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 2nd (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 2nd, 1929, to —, 19—
that I last saw h[redacted] alive on Feb 2, 1929
and that death occurred, on the date stated above, at p m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of
Was there an autopsy? no was necessary
What test confirmed diagnosis? Own symptoms
(Signed) O Clemenger Coroner M. D.
Feb 3, 1929 (Address) Benewah Co. St Maries Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane Wn — Date of [illegible] on arrival.
20. Undertaker: Mitchell & Menager — Address St Maries Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65194

Registration District No. 32
Primary Registration District No. 204-9
Local Registrar's No. 4

PLACE OF DEATH
County of Benewah
City of St Maries
(No. St Maries Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Patrick Joseph Casey

(a) Residence No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 17 - 1901

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	4	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work woodsman
(b) General nature of industry, business, or establishment in which employed (or employer) sawyer
(c) Name of employer Blackwell Lbr Co

9. BIRTHPLACE (city or town) (State or country) County Louth Ireland.

PARENTS

10. NAME OF FATHER Patrick Joseph Casey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.
12. MAIDEN NAME OF MOTHER Mary Dowdal
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland.

14. Informant Birth Reg Papers Gen Reg Office
(Address) Dublin

15. Filed Feb 2, 1929 W Menagh
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/15, 1929, to 2/1, 1929
that I last saw him alive on 2/1, 1929
and that death occurred, on the date stated above, at 8:10 P. m.
The CAUSE OF DEATH* was as follows:
Influenza Pneumonia
Complicated by empyema
(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death Blackwell Lbr Co, Camp 2 Idaho
Did an operation precede death? yes Date of 1/28/29
Was there an autopsy? No
What test confirmed diagnosis? Clinical and operation
(Signed) C A Robins M. D.
Feb, 1929 (Address) St Maries, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Woodlawn	Feb 5 1929
20. Undertaker	Address
Mitchell & Menagh	St Maries Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65195

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 60

2. FULL NAME ALEXANDER GOULD

(a) Residence. No. ..... St. BOISE, IDAHO
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 50 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 82 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED: Retired
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): N. Brunswick, Canada

PARENTS

10. NAME OF FATHER: ---
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ---
12. MAIDEN NAME OF MOTHER: ---
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ---

14. Informant: J. E. Wilson Att.
(Address) Blackfoot, Idaho.

15. Filed Mar 22, 1929 Mrs Walter E. Fabrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 22-1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1929, 19 to Mar 22-1929, 19
that I last saw him alive on Mar 22nd-1929, 19
and that death occurred, on the date stated above, at 6:25P m.
The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
Mar 22nd, 1929 (Address) Blackfoot I

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Asylum Cem. | Date of Burial: Mar. 25 1929

20. Undertaker: J. A. Barley | Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65196

PLACE OF DEATH
County of Bingham — Registration District No. 116
City of Aberdeen — Primary Registration District No. 2195 — Local Registrar's No. 22
(No. ....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Salley Emsley

(a) Residence. No. .... St. Aberdeen Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred .... yrs. .... mos. .... ds. How long in U. S., if of foreign birth? .... yrs. .... mos. .... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Rufus W Emsley

6 DATE OF BIRTH (month, day and year): may 18 60

7 AGE: Years 68 | Months 10 | Days — | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ....
(c) Name of employer: ....

9 BIRTHPLACE (city or town) (State or country): Blain, Minn Co, Georgia

PARENTS
10 NAME OF FATHER: Bert- Cook
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: martha mulkey
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: R W Emsley
(Address): Aberdeen Ida

15 Filed: March 18 25 Mcsmeekinnon. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 18 (Month) (Day) 1925 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1925, to March 18, 1925, that I last saw h. alive on March 18, 1925, and that death occurred, on the date stated above, at 2 40 P m.

The CAUSE OF DEATH* was as follows:
Chronic nephritis
.... (duration) unknown yrs. .... mos. .... ds.
CONTRIBUTORY (Secondary) Cerebral apoplexy.
.... (duration) .... yrs. .... mos. 2 ds.

18 Where was disease contracted if not at place of death? ....
Did an operation precede death? No Date of ....
Was there an autopsy? No
What test confirmed diagnosis? none (Urinalysis)
(Signed) Mcsmeekinnon, M. D.
March 18, 1925 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Aberdeen Idaho — Date of Burial: March 20 1925
20. Undertaker: A W Davis — Address: Aberdeen Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

current complete January 1929

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65197

PLACE OF DEATH

County of Fr. Hall Reservation, Idaho.

City of

Registration District No. 121

Primary Registration District No. 2194-R

Local Registrar's No. 44

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Tendey (Toopompy Tendow)

(a) Residence. No. ---- St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Shoshone Indian 4/4

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Nena Bear.

6. DATE OF BIRTH (month, day and year): 1865

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
64	---	---	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: --

9. BIRTHPLACE (city or town) (State or country): Lemhi Reservation

PARENTS

10. NAME OF FATHER: Chief Tendey

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Lemhi Reservation

12. MAIDEN NAME OF MOTHER: Tune-gah-go

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Lemhi Reservation

14. Informant: Jack Tendey.
(Address) Blackfoot, Idaho.

15. Filed Mar. 10, 1929 Mrs Walter E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 6, 1929 (Month) (Day) (Year) 19
No doctor attending

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 3: A.m.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) ---

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ---

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Coroners inquest

(Signed) Henry R. Whale, M. D.

---, 19 (Address) Ft. Hall, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Presbyterian Mission Ft. Hall Reservation,

Date of Burial: Jan. 12, 1929

20. Undertaker: Brown, Eldredge, Blackfoot, Ida.

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

current complete. January 1929.

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65198

PLACE OF DEATH

County of Ft. Hall Reservation, Idaho.

City of .....

Registration District No. 121

Primary Registration District No. 2194-R

Local Registrar's No. 45

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maude Pohipe.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Shoshone Indian 4/4

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Leon Pohipe

6. DATE OF BIRTH (month, day and year): 1906

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
23	--	--	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): ---

(c) Name of employer: ----

9. BIRTHPLACE (city or town) (State or country): Ft. Hall Reservation

PARENTS

10. NAME OF FATHER: Frank Willett.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ft. Hall Reservation

12. MAIDEN NAME OF MOTHER: Louise Venus

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ft. Hall Reservation

14. Informant: Frank Willett.
(Address) Ft. Hall, Idaho.

15. Filed Mar. 10, 1929 Mrs Walter E Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 31, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Apr. 20, 1923, to Jan. 31, 1929 that I last saw her alive on Jan 21, 1929, 19 and that death occurred, on the date stated above, at 9: P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs.

(duration) 5 yrs. 9 mos. 11 ds.

CONTRIBUTORY (Secondary) ---

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ---

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) Henry N. Wheeler, M. D.

---, 19 (Address) Ft. Hall, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ft. Hall Reservation

Date of Burial: Feb. 4, 1929

20. Undertaker: Frank Willett,

Address: Ft. Hall, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1929 Complete. February 1929.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65199

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ft. Hall Reservation

City of Idaho.

Registration District No. 121

Primary Registration District No. 2194-R

Local Registrar's No. 46

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harrison Timsanice.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Shoshone Indian 4/4

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: -----

6. DATE OF BIRTH (month, day and year): Oct. 2, 1921

7. AGE: Years 7, Months 4, Days 3. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): ----

(c) Name of employer: ---

9. BIRTHPLACE (city or town) (State or country): Ft. Hall Reservation

PARENTS

10. NAME OF FATHER: Percey Timsanice

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ft. Hall Reservation

12. MAIDEN NAME OF MOTHER: Louise Chank

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ft. Hall Reservation

14. Informant: Percey Timsanice.
(Address) Ft. Hall, Idaho.

15. Filed Mar. 18, 1929 Mrs Walter E. Palmer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 5, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1928, to Feb. 5, 1929, that I last saw him live on B Feb. 5, 1929, and that death occurred, on the date stated above, at 9: P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

..... (duration) ..... yrs. 11 mos. 10 ds.

CONTRIBUTORY (Secondary): ---

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ---

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Henry R. Wheeler M. D.

--, 19 (Address) Ft. Hall, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ft. Hall Reservation, Date of Burial: Feb. 8, 1929

20. Undertaker: H. L. Mc. Han, Pocatello, Address: Idaho.

current complete February 1929.

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65200

PLACE OF DEATH

County of Ft.Hall Reservation, Idaho.

City of

Registration District No. I2I

Primary Registration District No. 2I94-R

Local Registrar's No. 47

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jessie Jackson

(a) Residence. No. --- St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Shoshone Indian 4/4

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6. DATE OF BIRTH (month, day and year) Feb. I6, I9I9

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
9	II	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9. BIRTHPLACE (city or town) (State or country) Ft.Hall Reservation

PARENTS

10. NAME OF FATHER Peter Jackson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Inkom, Idaho.

12. MAIDEN NAME OF MOTHER Nellie Jackson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ft.Hall Reservation

14. Informant Peter Jackson,
(Address) Ft.Hall, Idaho.

15. Filed Mar. I8, 1929 Mrs Walter E Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb.8, I929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 2I, 1929, to Feb. 28, 1929 that I last saw her alive on Feb. 8, I929, 19 and that death occurred, on the date stated above, at 6: A m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis, Cerebral

(duration) yrs. mos. I8 ds.

CONTRIBUTORY (Secondary) ---

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ---

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Henry R. Wheeler M. D.

---, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ft.Hall Reservation
Date of Burial: Feb.I0, I929

20. Undertaker: Shoemaker & Beasley, Pocatello, Idaho
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

current complete ... ruary 1929

RECEIVED APR 8 1929

STATE ... DEPARTMENT OF ... BUREAU OF VITAL ...

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65201

County of Ft. Hall Reservation, Idaho

City of

Registration District No. 121

Primary Registration District No. 2194-R

Local Registrar's No. 48

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lewis Dorsey

(a) Residence. No. --- St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Shoshone Indian, 4/4

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: -----

6. DATE OF BIRTH (month, day and year): 1900

7. AGE: Years 29; Months --; Days ---; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED: Farming

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): --

(c) Name of employer: ---

9. BIRTHPLACE (city or town) (State or country): Owyhee, Nevada

PARENTS

10. NAME OF FATHER: Willie Dorsey

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Owyhee, Nevada

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Joseph Paddy.

(Address): Owyhee, Nevada.

15. Filed Mar. 18, 1929 Mrs Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 12, 1929 (Month) (Day) (Year) 19

No doctor attending

17. I HEREBY CERTIFY, That I attended deceased from --- , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 11, P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ----

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry R. Wheeler, M. D.

--- , 19 (Address) Ft. Hall, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ft. Hall Reservation, Feb. 15, 1929 19 — Date of Burial

20. Undertaker: Modern Mortuary, Blackfoot, Ida. — Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

current complete February 1929

RECEIVED APR 8 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65202

County of Ft. Hall Reservation, Idaho.
City of
Registration District No. 121
Primary Registration District No. 2194- R
Local Registrar's No. 49
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sallie Edmo

(a) Residence. No. ----- St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Shoshone Indian 4/4
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Leonard Edmo
6. DATE OF BIRTH (month, day and year): 1904
7. AGE: Years 25 | Months -- | Days -- | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): --
(c) Name of employer: ---
9. BIRTHPLACE (city or town) (State or country): Ft. Hall Reservation

PARENTS
10. NAME OF FATHER: Noveetse
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Won-go-air-o-pong.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Leonard Edmo.
(Address) Ft. Hall, Idaho.
15. Filed Mar. 18, 1929 W. McCaleb E. Eatmore. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 17, 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1920 to Feb. 17, 1929, that I last saw her alive on Feb. 16, 1929, and that death occurred, on the date stated above, at 4: P m.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) 9 yrs. 0 mos. 14 ds.
CONTRIBUTORY (Secondary): ---
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ---
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Microscope
(Signed) Henry M. Erkens, M. D.
-- 19 (Address) Ft. Hall, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ft. Hall Reservation, Date of Burial: Feb. 20, 1929
20. Undertaker: Shoemaker & Beasley, Address: Pocatello, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65203

Registration District No. 21
Primary Registration District No. 2194
Local Registrar's No. 50

PLACE OF DEATH
County of Bingham
City of Blackfoot Ida R.D. #5
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ralph Lewis Clyde

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 1, 1929

7. AGE — Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot, Ida

PARENTS
10. NAME OF FATHER James Reese Clyde
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Alta Law
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant James R. Clyde
(Address) Blackfoot R. 5

15. Filed Mar 2, 1929 W. McWaden Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929, to Mar 2, 1929
that I last saw him alive on Mar 1, 1929
and that death occurred, on the date stated above, at 3:000 m.
The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Premature Birth
Placenta Previa
(duration) yrs. 7th 2nd

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. W. Beck, M. D.
Mar 2, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Blackfoot	Mar. 2 1929
20. Undertaker: James R. Clyde	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65204

[redacted] OF DEATH
County [redacted]GHAM
City of [redacted]FOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTHIDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 51

FULL NAME MARCELINA ALDAPE

(a) Residence. No. ..... St. BOISE IDAHO
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 35 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: FRANK ALDAPE

6. DATE OF BIRTH (month, day and year)

7. AGE: About 45 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: HOUSEWIFE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Spain

PARENTS

10. NAME OF FATHER: --
11. BIRTHPLACE OF FATHER (city or town) (State or Country): --
12. MAIDEN NAME OF MOTHER: --
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): --

14. Informant: Anne Fedorka Att.
(Address) Blackfoot, Idaho.

15. Filed Mar 4, 1929. Wm Walter E. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 3rd, 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 28th 1929, 19 to Mar 3rd, 1929, 19
that I last saw her alive on Mar. 3rd-1929, 19
and that death occurred, on the date stated above, at 5:10 P m.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach,
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo Williams M. D.
Mar. 4th, 1929, 19 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burial Idaho | Date of Burial 19

20. Undertaker: E J Peck | Address: Blackfoot Ida

MARGIN RES[redacted] FOR BINDING
WRITE PLAINLY, WITH UNFADING [redacted]—THIS IS A PERMANENT
N. B.—Every item of information should be carefully supplied. AGE should be stated should state CAUSE OF DEATH in plain terms, so that it may be properly classified. E[redacted]TION is very important. See instruction on back of certificate.

FORM V. S. RECEIVED APR 8 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1 2 1
Primary Registration District No. 1 0 0 7
(No. ....., ... St.)

File No. 65205
Registered No. 52

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Goodwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. March (Month) 5 (Day) 1929 (Year)

7. AGE ✓ Yrs. ✓ Mos. ✓ ds.
IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bingh Co Idaho

10. NAME OF FATHER J. E. Goodwin

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Helen Edna Parson

13. BIRTHPLACE OF MOTHER (State or Country) Bingham Co Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. E. Goodwin
(Address) 171 No pine Blackfoot Ida.

15. Filed Mar 6 1929 Mrs Walter E. Pate
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 5th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on March 5th 1929, to ..... 191...,
that I last saw him alive on March 5th 1929,
and that death occured on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:
Congenital aortic regurgitation

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Hampton M. D.
3/8 1929 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Green City Cemetery
DATE OF BURIAL: 3-6 1929

20. UNDERTAKER: E. F. Peck
ADDRESS: Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BRNS. 24653

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65206

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 53

2. FULL NAME Echo Beth Dial
(a) Residence. No. Shelley Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) March-7-1929

7. AGE Years Months Days If LESS than 1 day, 3 hrs. or 15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley Idaho

PARENTS
10. NAME OF FATHER Harry Dial
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Shelley Ida
12. MAIDEN NAME OF MOTHER Bessie Clark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Jamestown Idaho

14. Informant Harry Dial
(Address) Shelley Idaho

15. Filed March 7, 1929 Mrs Walter E Fabrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 7" 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 7, 1929, to Mch 7, 1929
that I last saw her alive on Mch 7, 1929
and that death occurred, on the date stated above, at 4 A m.
The CAUSE OF DEATH* was as follows:
Premature Beth
Cause not known
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) F E Roberts M.D., M. D.
Mch 7, 1929 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley, Idaho
Date of Burial Mch 7 - 1929

20. Undertaker None Employed.
Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Shelley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ..... St.)

File No. 65207

Registered No. 5-4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Keith Howard Oler.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 3 (Month) 10 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Babe

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shelley Idaho.

10. NAME OF FATHER: Donald John Oler.

11. BIRTHPLACE OF FATHER (State or Country): American Fork Utah

12. MAIDEN NAME OF MOTHER: Mary Ellen Young

13. BIRTHPLACE OF MOTHER (State or Country): Shelley Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Donald J. Oler.

(Address) Shelley Ida.

15. Filed March 13 1929 Mr Walter E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3. (Month) 13. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-10- 1929, to 3-13- 1929 that I last saw him alive on 3-13- 1929 and that death occurred on the date stated above, at 4 30 a.m. M.

The CAUSE OF DEATH* was as follows:

Convulsions accompanying acute indigestion (Mother had acute Nephritis for about 6 weeks preceding birth.) (Duration) ..... Yrs. ..... mos. 6 hrs

Contributory (Secondary) Infantile Jaundice

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Edwin Cutler M. D.

3-13 1929 (Address) Shelley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelley Cemetery

DATE OF BURIAL: 3-13- 1929

20. UNDERTAKER: none Employed

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED APR 8 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65208
Local Registrar's No. 5

1. PLACE OF DEATH
County of Bingham
City of Shelley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2144
(No. ..... St.)

2. FULL NAME Clarence Robinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Jan (Month) 5 (Day) 1893 (Year)

7. AGE: 36 Yrs. 2 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): General farming

9. BIRTHPLACE (State or Country): American Fork Utah

10. NAME OF Father: Geo. A. Robinson

11. BIRTHPLACE OF FATHER (State or Country): American Fork Utah

12. MAIDEN NAME OF MOTHER: Mary C. Williams

13. BIRTHPLACE OF MOTHER (State or Country): Rush Valley Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wilburn Robinson
(Address) Shelley Idaho

15. Filed March 18 1929 Mrs Walter E. [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 14th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1929 to Mch 14 1929 that I last saw him alive on Mch 13th 1929, and that death occurred on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Ty Lord Fever

(Duration) ..... yrs. 2 mos. ..... ds.

Contributory (Secondary) Empyemia

(Duration) ..... yrs. ..... mos. 15 ds.

(Signed) [illegible] M. D.

Mch 15 1929 (Address) Shelley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? ✓
Former or usual residence Same

19. PLACE OF BURIAL OR REMOVAL: Shelley Cemetery
DATE OF BURIAL: Mch 19 1929

20. UNDERTAKER: Clifford A. Hayes
ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65209

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT
Registration District No. 131
Primary Registration District No. 7194
Local Registrar's No. 5
(No. South Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME EUGENIO SALCIDO

(a) Residence No. ..... St. State Penitentiary
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 17 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	MEXICAN	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chihuahua, Old Mexico

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unkown
12. MAIDEN NAME OF MOTHER ----
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ----

14. Informant C. E. O'Rourke Att.
(Address) Blackfoot, Idaho.

15. Filed Mar 29, 1929 McWaters Ed Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 16th, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1928 to Mar 16th, 1929
that I last saw him alive on March 16th, 1929
and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

Syphilis
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo. Hillings, M. D.
Mar 22, 1929. (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Asylum Cem.	
20. Undertaker Joseph Bailey	Address Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65210

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 131
Primary Registration District No. 1007
Local Registrar's No. 57
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clyde Hudson Jr.

(a) Residence. No. 90 S. Fisher St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 7 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 24 1922

7. AGE	Years	Months	Days	If LESS than 1 day,
	6	7	22	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Clyde Hudson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) South Dakota
12. MAIDEN NAME OF MOTHER Jennie May Downing
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Harry Clyde Hudson
(Address) Blackfoot

15. Filed March 8 1929 Mo Coleen E Tobie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17, 1929, to March 17, 1929
that I last saw him alive on March 17, 1929
and that death occurred, on the date stated above, at 3:15 P m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) yrs. mos. 15 Min

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W W Beck, M. D.
3/18, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Groveland Cemetery	March 19 1929
20. Undertaker E J Peck	Address Blackfoot Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 8 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 1007

File No. 65211

Registered No. 3-8

County of Bingham

City of Blackfoot (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joy Marie Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 5 (Day) 1926 (Year)

7. AGE: Yrs. 6 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot

10. NAME OF FATHER: J. Lloyd H. Roberts

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mullen Hardcastle

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Hardcastle

(Address) Blackfoot Idaho.

15. Filed March 19 1929 M. McCalen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-12 1929, to ..... 191..., that I last saw h[illegible] alive on 3-12 1929 and that death occured on the date stated above, at 12:01 A.M.

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Hardcastle M. D.

3-16 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland Cemetery — DATE OF BURIAL: 3-19 1929

20. UNDERTAKER: E. J. Peck — ADDRESS: Blackfoot

BYRNE - YORK CO., PTRS. & RGRS. 24658

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ..... St.)

File No. 65212

Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bethel Noak Noack

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Feb (Month) 26 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: X

(b) General nature of industry, business or establishment in which employed (or employer): X

9. BIRTHPLACE (State or Country): Blackfoot Idaho

10. NAME OF FATHER: David J. Noack

11. BIRTHPLACE OF FATHER (State or Country): Blackfoot Idaho

12. MAIDEN NAME OF MOTHER: Gladys Walters

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David J. Noack

(Address) Blackfoot Ida. Route #2

15. Filed Mar 20 1929 Mrs Walter E. Fabrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Mch 19 1929, to ..... 19....., that I last saw her alive on Mch 19 1929, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Humphrey M. D.

3/20 1929 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thomas Riverside

DATE OF BURIAL: Mar 21 1929

20. UNDERTAKER: David J. Noack

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65213

PLACE OF DEATH
County of Bingham
City of Blackfoot RD#1

Registration District No. 121
Primary Registration District No. 2194
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 61

2. FULL NAME George Ruben Moses
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Moses

6. DATE OF BIRTH (month, day and year): July 12, 1866

7. AGE: Years 62 Months 8 Days 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Self

9. BIRTHPLACE (city or town) (State or country): Fairview, Utah

PARENTS

10. NAME OF FATHER: George R. Moses
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Alice Christy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: I A Ellis
(Address) Blackfoot R1

15. Filed Mar. 26, 1929 Mrs Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25, 1929, to March 25 1929 that I last saw him alive on Was dead when I arrived and that death occurred, on the date stated above, at 6:20 A m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) W W Beck, M. D.
3/26, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Groveland Am. Date of Burial: 3-27 1929

20. Undertaker: E. T. Peck. Address: B.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65214

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 131

Primary Registration District No. 3194

Local Registrar's No. 62

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Rodney Peterson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Nov 16 1910

7. AGE: Years 18 Months 4 Days 12. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: In School

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Joseph Utah

PARENTS

10. NAME OF FATHER: James Peterson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Richfield Utah

12. MAIDEN NAME OF MOTHER: Sarah Ann Carlin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Joseph Utah

14. Informant: James Peterson

(Address): Fairth Idaho

15. Filed: Mar 29, 1929 Mrs Walter E Watkins Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to March 29, 1929

that I last saw him alive on March 29, 1929

and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Abscess of Liver

..... (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) F. U. Mitchell, M. D.

March 29, 1929 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Dyc Cemetery Firth

Date of Burial: 19

20. Undertaker: E J Peck

Address: Blackfoot

RECEIVED APR 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65215

PLACE OF DEATH
County of Blaine
City of Ketchum
Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 3
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ann Price

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: W. M. Price

6. DATE OF BIRTH (month, day and year): Nov 20 1848

7. AGE — Years: 80 | Months: 2 | Days: 11 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Plainville Indiana

PARENTS
10. NAME OF FATHER: Joseph Marlatt
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Carrie E. Price
(Address): Ketchum Idaho

15. Filed 2-1, 1929 R. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

Wright

16. DATE OF DEATH: Feb 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-25, 1929, to 2-1, 1929
that I last saw h[er] alive on 2-25, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Influenza -
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) R. H. Wright, M. D.
2-2, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ketchum Ida — Date of Burial: Feb 3 1929
20. Undertaker: Harris & Amos — Address: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65216

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

2. FULL NAME Rose Marie Chess

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
girl	White	

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec-5-28

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Hailey Idaho

PARENTS

10. NAME OF FATHER Jesse Chess.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Douglass Co. Mo.
12. MAIDEN NAME OF MOTHER Celia Bradley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Marshall Madison Co. N. C.

14. Informant O. J. Bradley
(Address) Hailey Idaho

15. Filed 3-1, 1929 Robert H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/4, 1929, to 2/7, 1929
that I last saw h.e alive on 2/7, 1929
and that death occurred, on the date stated above, at 12 mid. m.
The CAUSE OF DEATH* was as follows:
Enteritis
..... (duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. W. Fox, M. D.
2/7, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey Idaho	Feb 4 19
20. Undertaker E244 Harris & Amos	Address Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

65217

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 5

RECEIVED APR 2 1929

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Normington
(a) Residence. No. Hailey Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

Tox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Lena Normington

6. DATE OF BIRTH (month, day and year) May 12, 1860

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Mining
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER ✓
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Katherine Normington Hoy
(Address) Boise Idaho

15. Filed 3-1, 1929 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/10, 1929 to 2/11, 1929
that I last saw h— alive on 2/11, 1929
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Cardiac Arrhythmia
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Arteria sclerosis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. W. Hoy, M. D.
2/19, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey Idaho	Feb 13 1929
20. Undertaker	Address
Harris & Anor	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 2 1929

RECEIVED APR 2 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65218

County of Blaine

City of Hailey

Registration District No. 57

Primary Registration District No. 2022

Local Registrar's No. 6

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alice Yochey

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of A. J. Yochey.

6. DATE OF BIRTH (month, day and year) Oct 23 - 1873

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	4	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Geo Turner

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Rice

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant A J Yochey

(Address)

15. Filed 3 - 1, 1929 Robert H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2 - 10, 1929, to 2 - 13, 1929 that I last saw her alive on 2 - 13, 1929 and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Diabetis Melitis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert H. Wright M. D.

2 - 14, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey Idaho — Date of Burial: Feb 16 1929

20. Undertaker Harris & Anon — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 2 1929

PLACE OF DEATH

County of Blaine

City of Hailey

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 57

Primary Registration District No. 2022

(No. Hailey Clinical Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65219

Local Registrar's No. 7

2. FULL NAME Richard Abraham Shaw.

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ——

6. DATE OF BIRTH (month, day and year): Dec 25 - 1889

7. AGE: Years 39 | Months 1 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Richfield Utah.

PARENTS

10. NAME OF FATHER: Richard Shaw

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Gunnison, Utah

12. MAIDEN NAME OF MOTHER: Ada Ainsworth

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Burt Shaw

(Address): Green River Wyoming

15. Filed 3-1, 1929 R. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/20, 1929, to 2/21, 1929, that I last saw h— alive on 2/21, 1929, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

..... (duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? Sawtelle, Idaho

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E W [illegible], M. D.

2/25, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal	Date of Burial
Hailey Idaho	Feb 25 1929
20. Undertaker: Harris & Anson	Address: Hailey

RECEIVED APR 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65221

PLACE OF DEATH
County of Blaine
City of Gannett

Registration District No. 57
Primary Registration District No. 2022
(No.) FOX
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

2. FULL NAME Victor Lilya

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of May Lilya

6. DATE OF BIRTH (month, day and year) Nov 15 1859

7. AGE Years 59 Months 3 Days 13 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER O. A. Lilya
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER X
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant L. B. Lilya
(Address) Gannett, Ida

15. Filed 3-31, 1929 Robert H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-26, 1929, to 2/28, 1929
that I last saw him alive on 2/28, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage following Influenza
(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. W. [illegible], M. D.
2/29, 1929 (Address) E. W. [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Timmerman Cem
Date of Burial Mar 2 1929

20. Undertaker Harris & Amos
Address Hacley

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65222

PLACE OF DEATH

County of Blaine
City of Hailey
Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 10
(No. Hailey Clinical Hosp.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Edward Anderson

(a) Residence. No. Farm, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Nora Anderson

6. DATE OF BIRTH (month, day and year) Apr 5 - 1884

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	11	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Springfield Ill.

PARENTS

10. NAME OF FATHER Charles Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Springfield Ill.
12. MAIDEN NAME OF MOTHER Laura Temple
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Mrs Nora Anderson
(Address) Carey - Idaho

15. Filed 3-31, 1929 Robert H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/4, 1929 to 3/6, 1929
that I last saw him alive on 3/6, 1929
and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:
Pernicious Anemia following ruptured Ulcer of Bladder
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 3/5-29
Was there an autopsy? No
What test confirmed diagnosis? Clinical

3/7, 1929 (Signed) E W Wright, M. D.
(Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Idaho	May 9th 1929
20. Undertaker E244 Harris & Amon	Address Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65223

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

2. FULL NAME Gus Johnson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Velma Johnson

6. DATE OF BIRTH (month, day and year) Sept 17 1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	5	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer & Stock
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER Thomas Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER X
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Velma Johnson
(Address) Hailey

15. Filed 3-31, 1929 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

FOX

16. DATE OF DEATH March 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/5, 1929 to 3/10, 1929
that I last saw h. alive on 3/10, 1929
and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:
Interstitial nephritis
acute
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) E. E. Fox, M. D.
3/11, 1929 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey	March 12 1929
20. Undertaker	Address
Harris & Amos	Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65224

• PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 54
Primary Registration District No. 2022
Local Registrar's No. 12
(No. Hailey Clinical Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cora A Baptie

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Thomas Baptie

6. DATE OF BIRTH (month, day and year): Jan 22 1885

7. AGE: Years 44 | Months 1 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: James Dillard
11. BIRTHPLACE OF FATHER (city or town) (State or Country): X
12. MAIDEN NAME OF MOTHER: X
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Thomas Baptie
(Address) Carey Idaho

15. Filed 3-31, 1929 Robert H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19, 1929, to 3/19, 1929, that I last saw him alive on 3/19, 1929, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:
Carcinomatosis abdominal Peritoneum

(duration) ... yrs. 6 mos. ... ds.
CONTRIBUTORY (Secondary) atrophic Cirrhosis
(duration) 1 yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 1/19-29
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) E. W. [illegible], M. D.
3/19, 1929 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Carey Idaho	Mar 21 1929
20. Undertaker	Address
Harris & Amos	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65225

PLACE OF DEATH

County of Bonner

City of Morton

Registration District No. 85

Primary Registration District No. 2185

Local Registrar's No. 3

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bertha C. Campbell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of J.H.Campbell

6. DATE OF BIRTH (month, day and year) Feb. 7, 1870

7. AGE	Years	Months	Days	If LESS than 1 day,
	58	11	21	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Nodaway
(State or country) Iowa

PARENTS

10. NAME OF FATHER S. P. Kennedy

11. BIRTHPLACE OF FATHER (city or town) Virginia
(State or Country)

12. MAIDEN NAME OF MOTHER Rachel Patterson

13. BIRTHPLACE OF MOTHER (city or town) Scotland
(State or Country)

14. Informant J. H. Campbell
(Address) Morton, Idaho.

15. Filed Feb. 2, 1929 R. E. Wessa
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January (Month) 28th. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
1/26, 1929, to 1/27, 1929
that I last saw her alive on 1/27, 1929
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction and
Peritonitis, acute

..... (duration) one yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) T. J. Pettit M.D. M. D.

Jan. 28th, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Seneacqouteen Cemetery	Feb. 3, 1929

20. Undertaker	Address
L. R. Moon.	Sandpoint, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 0 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65226

PLACE OF DEATH
County of Bonner
City of Vay

Registration District No. 85
Primary Registration District No. 2185
(No.)

Local Registrar's No. 5

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME William Kenny

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lou Belshe Kenny

6 DATE OF BIRTH (month, day and year) Dec. 25, 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	2	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Boyle,
(State or country) Roscommon County, Ireland

PARENTS

10 NAME OF FATHER John Kenny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) County Cavin Ireland

14 Informant C W Kenny.
(Address) Moon Ore

15 Filed Mar. 10, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
March 8, 1929
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1929, to March 7, 1929, that I last saw h.im alive on March 7th, 1929, and that death occurred, on the date stated above, at 12:40 P. m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) H.B. Pneumonia, Nephritis
Myocarditis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical Signs
(Signed) L L Sparks M. D.
March 10 1929 (Address) Priest River Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Seneacquoteen Cemetery	Mar. 10, 1929
20. Undertaker	Address
Moon Mortuary	Priest River

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 65227

PLACE OF DEATH

County of Bonner

City of Priest River

CERTIFICATE OF DEATH

Registration District No. 85

Primary Registration District No. 2185

(No. Priest River Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 6

2. FULL NAME William M. Sellentine

(a) Residence. No. ..... St. Laclede, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day and year): Unknown

7 AGE: About 56 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Graves

(Address) Laclede, Idaho.

15 Filed Mar. 22, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 19, 1929 (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1928, to March 19, 1929, that I last saw him alive on March 19, 1929, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows: Lentic Myocarditis - Gummas of Larynx

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary): Syphilis

(duration) unknown yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] A. Lower, M. D.

March 22 1929 (Address) Priest River Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: I. O. O. F. Cemetery

Date of Burial: Mar. 22, 1929

20. Undertaker: Moon Mortuary

Address: Priest River

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65228

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 76
Primary Registration District No. 2155
Local Registrar's No.
(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sam B. Goodman

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Humbird

9. BIRTHPLACE (city or town) Iowa
(State or country) ~~Unknown~~

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14. Informant Page Hospital
(Address) Sandpoint

15. Filed March 4, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 12, 1929, to Mch 3, 1929
that last saw h. alive on 3rd, March, 1929
and that death occurred, on the date stated above, at 12:20 P. m.

The CAUSE OF DEATH* was as follows:
Pernicious Anaemia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? dont know
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) O. F. Gage, M. D.
March 4, 1929 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of ~~Burial~~ Shipped
Hot Springs S Dakota	March 4 19
20. Undertaker	Address
Turnbull Co	Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65229

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 3155
Local Registrar's No.
(No. 411 N. Ella Avenue)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carrie McDumult Cramer.
(a) Residence. No. 411 N. Ella Avenue St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fred Cramer

6. DATE OF BIRTH (month, day and year) May 1, 1849.

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	10	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Dayton
(State or country) Ohio

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) Ohio
(State or Country)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14. Informant A. P. Martin (Son)
(Address) 411 N. Ella Ave. Sandpoint, Idaho.

15. Filed March 18, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 14, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-25, 1929, to 3-14, 1929, that I last saw h[er] alive on 3-14, 1929, and that death occurred, on the date stated above, at 4:10 A. m.
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage
due to old age Exhaustion
(duration) 2 yrs. — mos. — ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A. H. C. Olson, M. D.
3/16, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Mar. 17, 1929
20. Undertaker	Address
Moon Mortuary	Sandpoint, Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65230

PLACE OF DEATH
County of Bonner
City of Samuels

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Pearl Flossie Hoffine

(a) Residence. No. St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Paul Hoffine

6. DATE OF BIRTH (month, day and year) November 18th. 1909

7. AGE	Years	Months	Days	If LESS than 1 day,
	19	3	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Woodston
(State or country) Kansas

PARENTS

10. NAME OF FATHER Isaac Bonny

11. BIRTHPLACE OF FATHER (city or town) Newal County
(State or Country) Kansas

12. MAIDEN NAME OF MOTHER Floa E. Snow

13. BIRTHPLACE OF MOTHER (city or town) Rooks County
(State or Country) Kansas

14. Informant Paul Hoffine
(Address) Samuels, Idaho.

15. Filed March 18, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 16th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September, 1928, to March 16, 1929
that I last saw her alive on December 20th, 1928
and that death occurred, on the date stated above, at 11:30p m.
The CAUSE OF DEATH* was as follows:

Carcinoma of neck
(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Oct 30 1928
Was there an autopsy? no
What test confirmed diagnosis? Microscopic Section

(Signed) D. B. Evans, M. D.
3-18, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pack River Cemetery	MAR. 20, 1929
20. Undertaker MOON MORTUARY	Address Sandpoint, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65232

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 76
Primary Registration District No. 2155
(No. 316 N Ella)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Mrs Emma Grinolds

(a) Residence. No. 316 N Ella St.
(Usual place of abode)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Grinolds

6. DATE OF BIRTH (month, day and year): apr 9 1862

7. AGE — Years: 66 | Months: 11 | Days: 12 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Minn.

PARENTS

10. NAME OF FATHER: Shaw
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wisc
12. MAIDEN NAME OF MOTHER: A. Corkwright
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wisc

14. Informant: Milford + Grinolds
(Address): 327 S Main

15. Filed March 25 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15, 1929, to Mar 21, 1929
that I last saw her alive on Mar 13, 1929
and that death occurred, on the date stated above, at 5:40 P. m.
The CAUSE OF DEATH* was as follows:
Chr Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical

(Signed) R I Reno, M. D.
March 25, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sherwin Cemetery	3/25 1929
20. Undertaker	Address
Funeral Co	Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65233

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elnora Norman

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of C. D. Norman

6. DATE OF BIRTH (month, day and year) Sept. 27th. 1873

7. AGE: Years 55 | Months 6 | Days 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Andrew H. Arnold
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Susie Wolf
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant C. D. Norman
(Address) Sandpoint, Idaho.

15. Filed March 27, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 24th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1926, to Dec 20, 1928, that I last saw her alive on Dec 20, 1928, and that death occurred, on the date stated above, at 730 P m.

The CAUSE OF DEATH* was as follows:
Ac. Dilatation Heart.
Chr. Myocarditis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical

(Signed) T. E. Coss., M. D.
March 27, 1929 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sawyer, Idaho. Seneacquoteen Cemetery | Date of Burial: Mar. 28 1929

20. Undertaker: MOON MORTUARY | Address: SANDPOINT? IDA.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65234

PLACE OF DEATH
County of Bonner
City of Sagle
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME KATHERINE ELLEN FURY

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 4, ~~1913~~ 1912

7. AGE	Years	Months	Days	If LESS than 1 day,
	16	~~4~~ 5	~~25~~ 25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mare Arizona

PARENTS

10. NAME OF FATHER Robert A. Fury
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ontario, Canada.
12. MAIDEN NAME OF MOTHER Katherine Ellen Ferry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant Robt. A. Fury
(Address) Sagle, Idaho.

15. Filed March 30 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 29th, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to March 29, 1929
that I last saw h.e.r. alive on March 29, 1929
and that death occurred, on the date stated above, at 2 p. m.
The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Meningeal Complication without pulmonary

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) H. B. Evans, M. D.
Mar. 30, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Westmond Cemetery	Mar. 31, 1929
20. Undertaker MOON MORTUARY	Address Sandpoint, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65235

PLACE OF DEATH
County of Bonner
City of Sagle
Registration District No. 78
Primary Registration District No. 2155
(No. Sagle, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Emma Moore.

(a) Residence. No. Sagle, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Granville Moore

6. DATE OF BIRTH (month, day and year) Aug. I, I850.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	7	2I	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clay County, Ill.

PARENTS

10. NAME OF FATHER ASA Sullivan.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Whitley, Kentucky.
12. MAIDEN NAME OF MOTHER Russe.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky.

14. Informant C. E. Billips.
(Address) Sagle, Idaho.

15. Filed March 29 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 29, I929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1924, to ..., 19...
that I last saw her alive on ..., 1929
and that death occurred, on the date stated above, at I;30 P. m.

The CAUSE OF DEATH* was as follows:
Arterio-Sclerosis
Phrenic Myocarditis
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of 3-29-29
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Floyd G. Weadle, M. D.
3-29-, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hall Station, Missouri. Shipped to St. Joe, Mo.	19
20. Undertaker	Address
Moon Mortuary	Sandpoint, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65236

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 21-0
Local Registrar's No. 49
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clarabel Coleen Kruse
(a) Residence. No. 2 miles So of Idaho Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. 6 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): August 19-1924
7. AGE: Years 4, Months 6, Days 9; If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Idaho Falls. Idaho.

PARENTS
10. NAME OF FATHER: Fred Kruse.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.
12. MAIDEN NAME OF MOTHER: Lena Clarabel Byerly.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Holden Missouri

14. Informant: Fred Kruse.
(Address): Idaho Falls. Ida.
15. Filed Mar 2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 28. 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March, 1927, to Feb 28, 1929 that I last saw her alive on December, 1928 and that death occurred, on the date stated above, at 8 15 P. m.
The CAUSE OF DEATH* was as follows: Chronic Cerebro-Spinal meningitis.
(duration) 2 1/2 yrs. mos. ds.
CONTRIBUTORY (Secondary): Probably Acute Cerebro-Spinal meningitis about 3 years ago.
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Firth Idaho
Did an operation precede death? no Date of —
Was there an autopsy? No
What test confirmed diagnosis? Observation & History
(Signed) H. D. [signature] M. D.
March 3, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls. Ida. Date of Burial: 3/3 1929.
20. Undertaker: V. F. McHan Address: Idaho Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65237

PLACE OF DEATH

County of BOnneville

City of Shelton

Registration District No. 73

Primary Registration District No. 2 1 V 0

Local Registrar's No. 48

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Jane Cleverly

(a) Residence. No. Rigby, Idaho. Rouute #2. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Francis Cleverly

6. DATE OF BIRTH (month, day and year): Jan. 13, 1846.

7. AGE: Years 83 | Months 1 | Days 13 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House-wife.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: William Mills

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Ann Bishop

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Francis Cleverly
(Address): Rigby, Idaho. Route #2.

15. Filed Mar 2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 25, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1928, to Feb 1, 1929
that I last saw her alive on Feb 1, 1929
and that death occurred, on the date stated above, at 9:40A m.

The CAUSE OF DEATH* was as follows:
Myocarditis and Chronic Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) A. R. Sodenquist, M. D.
3/2, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ririe, Idaho
Date of Burial: Mar: 3 1929

20. Undertaker: Jack A. Wood
Address: Idaho Falls

RECEIVED MAR 31 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65238

Local Registrar's No. 47

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2170
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mont Carter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single

6. DATE OF BIRTH: Aug (Month) 27 (Day) 1923 (Year)

7. AGE: 5 Yrs. 6 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Provo, Utah

10. NAME OF Father: L W Carter

11. BIRTHPLACE OF FATHER (State or Country): Nephi, Utah

12. MAIDEN NAME OF MOTHER: LaVern Warren

13. BIRTHPLACE OF MOTHER (State or Country): Lehi Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): L W Carter
(Address): Blackfoot, Idaho

15.
Filed 4/2 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1929 to Feb 28 1929, that I last saw him alive on Feb 28 1929, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Meningococcic Cerebro-Spinal meningitis
(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) —
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W Ray Hatch M. D.
3/28/1929 (Address) Idaho Falls,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 7 days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? Blackfoot, Idaho
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nephi Utah
DATE OF BURIAL 19

20. UNDERTAKER: Modern Mortuary
ADDRESS Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65239

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 21 1-0

Local Registrar's No. 46

(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clesta Hansen

(a) Residence. No. Rigby, Idaho. Route NO.1. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Nephi Hansen

6. DATE OF BIRTH (month, day and year) June 9, 1900

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
28	8	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bloomington, Idaho

PARENTS

10. NAME OF FATHER John H. Thornock

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Farmington, Utah

12. MAIDEN NAME OF MOTHER Annslina Passey

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Paris, Idaho

14. Informant Nephi Hansen
(Address) Rigby, Idaho R.1.

15. Filed 2/27, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1928, to 2/23, 1929
that I last saw her alive on 2/23, 1929
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Partial abstruction of the (Jejunum) Jejunum

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Ch. Valvular Heart Disease

(duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Rigby, Idaho

Did an operation precede death? yes Date of Feb 16, 1929

Was there an autopsy? no

What test confirmed diagnosis? Wound explored.

(Signed) W. R. West, M. D.

2/26, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grant, Idaho

Date of Burial: Feb. 27 1929

20. Undertaker: Jack A Wood

Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65240

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 23

Primary Registration District No. 2140

Local Registrar's No. 46

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Blood

(a) Residence. No. Corner of Gladstone & Higbee St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 9, 1924

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	4	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho

PARENTS

10. NAME OF FATHER Enos Blood

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sevier County, Utah

12. MAIDEN NAME OF MOTHER Liddie Ames

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wyoming

14. Informant Enos Blood

(Address) Idaho Falls

15. Filed 2/27, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...

that I last saw him alive on No Doctor, 19...

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Epidemic Spinal Meningitis

..... (duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary)

..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal puncture

(Signed) [signature], M. D.

2/26, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rose Hill, Idaho Falls	Feb. 28 1929

20. Undertaker	Address
Jack A. Wood	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65241

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 13
Primary Registration District No. 2 1 N 0
Local Registrar's No. 44
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ~~Ale~~ Arlean Nelson

(a) Residence. No. 208 8th. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 23, 1925

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	7	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child at home.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER: Nels Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Ethel Byerly
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Nels Nelson
(Address): 208 8th. St. Idaho Falls

15. Filed 3/27, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23, 1929, to Feb 27, 1929
that I last saw her alive on Feb 27, 1929
and that death occurred, on the date stated above, at 1:30P m.
The CAUSE OF DEATH* was as follows:
Spinal Meningitis
(duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? not known
Did an operation precede death? — Date of —
Was there an autopsy? no
What test confirmed diagnosis? Diagnosis
(Signed) [signature], M.D.
Feb 27, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rose Hill, Idaho Falls	Feb. 28 19 29
20. Undertaker: Jack A Wood	Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Amended February 3, 1961

State File No. #65242

Federal Security Agency
United States Public Health Service
National Office of Vital Statistics

CERTIFICATE OF DEATH

STATE OF IDAHO

~~Local Registrar's Duplicate~~
Local Reg. No. 43
Reg. Dist. No. 73

1. PLACE OF DEATH:
(a) County Bonneville
(b) City or town Idaho Falls
(c) Street Address or R. F. D. No.
(d) Death Occurred Inside? Outside? city or town
(e) Died in a Home—Hospital—Institution—Other place
(f) Name Hosp. or Inst. L.D.S. Stayed days
(g) Lived in this county years months days
Note. For a person residing in THIS county LESS than 1 year, give FORMER residence under item 2.

2. Usual Residence of Deceased: (Always fill in these)
(a) State Idaho (b) County Bonneville
(c) City or town Ucon
(d) Street Address or R. F. D. No.
(e) Deceased lived Inside? Outside? city or town
(f) Citizen of what country?
(g) How long had deceased lived in Idaho? years
(h) Former residence (city, state)

3. (a) **FULL NAME** Mary E. Clegg

3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Fe
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Wm. J. Clegg
6. (c) Age of husband or wife if alive years
7. Date of Birth (Month, Day, Year) Dec. 22, 1869

8. AGE	Years	Months	Days	If less than 1 day
	59	2	1	hrs min.

9. Exact Occupation Housewife — Did this work for yrs.
10. Industry or Business — Date last worked
11. Birthplace Murray (City or town) Utah (State or foreign country)

Father
12. Name John Mudd
13. Birthplace England (City or town) (State or foreign country)

Mother
14. Maiden name Esther Barnes
15. Birthplace England (City or town) (State or foreign country)

16. Informant's **OWN** Signature W. J. Clegg
and Address Ucon, Idaho
17. (a) (Burial, cremation, or removal) (b) Date thereof Feb 27, 1929 (Month) (Day) (Year)
(c) Place: Ucon, Idaho
18. Funeral Director's **OWN** Signature Jack A. Wood
and Address Idaho Falls
19. (a) Feb 27, 1929 (Date received and filed) (b) WmKinnard (Registrar's signature)

MEDICAL CERTIFICATE OF DEATH

20. **DATE OF DEATH** (Month, Day, Year) February 23, 1929
At o'clock M.

21. **I HEREBY CERTIFY,** That I attended deceased from Feb 9, 1929, to Feb 23, 1929
I last saw her alive on Feb 23, 1929, death is said to have occurred on the date and hour stated above.

Immediate Cause of Death: — Duration

Adeno Carcinoma Thyroid — 1 yr
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

Where was disease contracted? Ucon, Idaho
Name of operation Date 2-11-29
Major finding
Finding of autopsy

Physician Underline the cause to which death should be charged statistically.

22. If death was due to **EXTERNAL CAUSES,** also fill in the following: Accident? Suicide? Homicide?
Occurred, 19 City, county, state where violence occurred
Place of Violence: Home Farm Industry
Public Place While at work?
Means of injury

23. Attendant's **OWN** Signature C. M. Cline, M.D.
and Address Idaho Falls (M. D. or other) Date Feb 23, 1929

(For additional space, use reverse side)

Family record that is obviously old gives the name John Mudd and his wife as Esther Barnes Mudd. Viewed byVS. And it gives Mary Elizebeth as their child.

IDAHO DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho } ss.
County of Bonneville

Certificate No. 65242

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)

for Mary E. Clegg (Name on Original Certificate) who died (Was Born or Died) on February 23, 1929 (Date of Event)

in Idaho Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
name of father	William Mood	John Mudd
name of mother	-----Barnes	Esther Barnes

Subscribed and sworn to before me this 27th day of January, 1961

George L. Jensen
Notary Public, residing at Idaho Falls Idaho
My commission expires May 10, 1962
(Seal)

Signed Hazel Jane Clegg
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Box 154 U Con, Idaho.
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Bonneville

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 27 day of January, 1961

George L. Jensen
Notary Public, residing at Idaho Falls, Idaho
My commission expires May 10, 1962
(Seal)

Signed Pauline Blackburn
(Signature of Any Credible Person)

285 Barlow Dr. Idaho Falls, Idaho
(Street Address, City, State)

FORM DH 60-155

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65242

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2170
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 43

2. **FULL NAME** Mary E. Clegg

(a) Residence. No. Ucon, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of William J. Clegg

6. DATE OF BIRTH (month, day and year) Dec. 22, 1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	2	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Murray, Utah

PARENTS

10. NAME OF FATHER William Mood

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER ----Barnes

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant W. J. Clegg
(Address) Ucon, Idaho

15. Filed 2/27, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9, 1929, to Feb 23, 1929
that I last saw her alive on Feb 23, 1929
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:

Adeno-Carcinoma Thyroid

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ucon Idaho
Did an operation precede death? Yes Date of Feb 11-29
Was there an autopsy? Yes
What test confirmed diagnosis? Pathological report
(Signed) [illegible], M. D.
2/23, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ucon, Idaho	Feb. 27 19 29
20. Undertaker	**Address**
Jack A. Wood	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65243

RECEIVED MAR 21 1929

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 214-0
Local Registrar's No. 4
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard J. Calonge

(a) Residence. No. Ashton, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 15, 1913

7. AGE	Years	Months	Days	If LESS than 1 day,
	16	1	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Jay Calonge
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Mary Hamlett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Jay Calonge
(Address) Ashton, Idaho

15. Filed Mar 21, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1929, to Feb 23, 1929
that I last saw him alive on Feb 23, 1929
and that death occurred, on the date stated above, at 7:30 P m.
The CAUSE OF DEATH* was as follows:
Abscess of brain
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) abscess of scalp
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? Ashton, Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Path.

(Signed) W. Ray Hatch M. D.
Feb 24, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ashton, Idaho	Feb 26 1929

20. Undertaker Jack A. Wood
Address Idaho Falls

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65244

PLACE OF DEATH
County of Bonneville. Registration District No. 13
City of Idaho Falls Primary Registration District No. 1210 Local Registrar's No. 41
(No. L-D-S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dow Williams

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 4 - 1854

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	1	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Preacher.
(b) General nature of industry, business, or establishment in which employed (or employer) Traveling Salesman
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Des Moines Iowa.

PARENTS

10. NAME OF FATHER Patrick Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.
12. MAIDEN NAME OF MOTHER Joan Mullins.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Burlington Vt.

14. Informant Patrick Williams.
(Address) Idaho Falls Ida

15. Filed 2/23, 1929 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 22 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1929, to Feb. 22, 1929
that I last saw h alive on Feb 22, 1929
and that death occurred, on the date stated above, at 2.45 A. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Pancreas.
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Same
(duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? California
Did an operation precede death? No Date of .....
Was there an autopsy? yes
What test confirmed diagnosis? autopsy
(Signed) H. D. Freeman, M. D.
2/22, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	Feb. 25 1929.

20. Undertaker W. F. McHan. Address Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65245

RECEIVED MAR 21 1929

PLACE OF DEATH
County of Bonneville. Registration District No.
City of Idaho Falls. Primary Registration District No.
Local Registrar's No. 40
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Josiah Cutler.

(a) Residence. No. 434 - 2 St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): April 19-1837
7. AGE: Years 91 | Months 10 | Days 3. | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Peoria Illinois

PARENTS
10. NAME OF FATHER: Isaac Cutler.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York.
12. MAIDEN NAME OF MOTHER: Sarah Metcalf.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio.

14. Informant: Mrs Josiah Cutler.
(Address): Idaho Falls Ida

15. Filed Dec 23, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Early in, 1920 to Feb. 22, 1929
that I last saw h alive on Feb 20, 1929
and that death occurred, on the date stated above, at 1020 A. m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Obstruction Prostate
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Urinary Analysis.
(Signed) H. D. Quick, M. D.
2/22, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	Feb 25 1929

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65246

Registration District No. 73

Primary Registration District No. 2140

Local Registrar's No. 39

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Merlyn Watson

(a) Residence No. Idaho Falls Route #7 St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 30, 1914

7. AGE Years 14 Months 7 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Robert S. Watson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary Rozlia Messervy

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wilford Utah

14. Informant Mr. Robert W. Watson
(Address) Idaho Falls Route #7

15. Filed Jul 4, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 6 P.M. m.

The CAUSE OF DEATH was as follows: Unknown — Probably small pox

No medical attendance (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M.D.

....., 19..... (Address) Idaho Falls Ohio

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho — Date of Burial February 1929

20. Undertaker Jack A. Wood — Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65247

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 13
Primary Registration District No. 2100
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

2. FULL NAME Leonard Ely Clifford

(a) Residence. No. 345 E. 20th St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alemeda Clifford

6. DATE OF BIRTH (month, day and year) Sept 1881

7. AGE Years 47 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Labour
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden, Utah

PARENTS

10. NAME OF FATHER Leonard Clifford
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Elizabeth Campbell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs. L. E. Clifford
(Address) Idaho Falls, Idaho

15. Filed Feb 23, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1929, to Feb 18, 1929
that I last saw him alive on Feb 18, 1929
and that death occurred, on the date stated above, at 3:53 p.m.
The CAUSE OF DEATH* was as follows:
General Peritonitis.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute diverticulitis (Sleeum) Chronic appendicitis several yrs. mos. ds.
(duration)

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of Feb-11-29
Was there an autopsy? No
What test confirmed diagnosis? Last operation Feb 17-29
(Signed) H D [signature], M. D.
2-23, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho
Date of Burial Feb. 24 1929

20. Undertaker Jack A. Wood
Address Idaho Falls

RECEIVED MAR 21 1929

FORM V. S. No. 5-25 M 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2 1 V - 0

(No. ..... St.)

State File No. 65249

Local Registrar's No. 36 -

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna M. Leavitt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word)

6. DATE OF BIRTH: Aug (Month) 22 (Day) 1891 (Year)

7. AGE: 38 Yrs. 5 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: H. P. Christensen

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Rose Black

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Vernal J. Leavitt

(Address) Blackfoot Ida

15. Filed Feb 20 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1929 to Feb 20 1929, that I last saw her alive on Feb 9 1929 and that death occurred on the date stated above, at 10:12 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

..... (Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary): Pregnancy

..... (Duration) ..... yrs. 7 mos. ..... ds.

(Signed) [signature] M. D.

2, 20 1929 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida

DATE OF BURIAL: Feb 1929

20. UNDERTAKER: E. T. Peck

ADDRESS: Blackfoot Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1929

PLACE OF DEATH

County of Bonneville

City of Iona

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65250

Registration District No. 73

Primary Registration District No. 210

Local Registrar's No. 30

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Susan Brunt

(a) Residence. No. Iona Idaho St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of George Brunt Sr.

6. DATE OF BIRTH (month, day and year) April 30

7. AGE Years 75 Months 9 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) London (State or country) England

PARENTS

10. NAME OF FATHER William James Burnett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Anna Denim

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant George Brunt

(Address) Idaho Falls, Idaho

15. Filed 2/19, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 14 1929 (Month) (Day) (Year)

on Dec 10 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1928, to —, 19..., that I last saw her alive on Feb, 1929, and that death occurred, on the date stated above, at 11.58 P m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

..... (duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) old age

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

Feb 20, 1928 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Rose Hill Idaho Falls Can. Date of Burial Feb. 19 1929

20. Undertaker Jack A. Wood Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65251

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 21N-0

Local Registrar's No. 34

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eva M. Powerton

(a) Residence. No. Idaho Falls Ida. 310 Shoupe St
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 6-1858

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70	8	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) West Union Iowa.

PARENTS

10. NAME OF FATHER James H. D. Pendleton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) East Port. Maine.

12. MAIDEN NAME OF MOTHER Susan E Eggleston

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Simcoe Canada

14. Informant Dr. G. W. Pendleton.
(Address) Idaho Falls Ida.

15. Filed 2/19, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17, 1929, to Feb 17, 1929
that I last saw her alive on Feb 17, 1929
and that death occurred, on the date stated above, at 1050 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) [signature], M. D.

Feb 19, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: Feb. 1929.

20. Undertaker: V. F. McHan Address: Idaho Falls

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65252

Local Registrar's No. 33

PLACE OF DEATH
County of Bonneville. Registration District No. 73
City of Idaho Falls Primary Registration District No. 21-4-0
(No. L.D.S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mabel Armetta Packer.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 17-29

7. AGE

Years	Months	Days	If LESS than 1 day,
0	0	0	3 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls (State or country) Idaho

PARENTS
10. NAME OF FATHER Parker. Idaho.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) William Packer
12. MAIDEN NAME OF MOTHER Mabel Walters
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Magna. Utah.

14. Informant William Packer.
(Address) Idaho Falls. Ida.

15. Filed 2/19, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 17 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17, 1929, to Feb 17, 1929
that I last saw h alive on Feb 17, 1929
and that death occurred, on the date stated above, at 4.00 P. m.
The CAUSE OF DEATH* was as follows:
Premature birth
(6 mos)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No ✓
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
....., 19..... (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls. Ida	2/19 1929.
20. Undertaker	Address
T. F. McHan	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65253

PLACE OF DEATH
County of Bonneville. Registration District No. 73
City of Idaho Falls. Primary Registration District No. 214-0
Local Registrar's No. 3
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jennie Burke.

(a) Residence No. 500-12 St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: J.G. Burke.

6. DATE OF BIRTH (month, day and year): July 4-1872

7. AGE: Years 56 | Months 7 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS
10. NAME OF FATHER: Gilbert Willy.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio.
12. MAIDEN NAME OF MOTHER: Ella Warden.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio.

14. Informant: J.G. Burke.
(Address): Idaho Falls Ida.

15. Filed 2/11, 1929 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 15 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from None, 19.., to .....
that I last saw her alive on .....
and that death occurred, on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:

Ch Myocarditis
(duration) 2 yrs. ..... mos.
CONTRIBUTORY (Secondary) Asthma
(duration) 10 yrs. ..... mos.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? Examination Today
What test confirmed diagnosis? History

(Signed) J.M. Rich M. D.
2-16, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida.	Feb 19 1929
20. Undertaker	Address
V.F. McHan.	Idaho Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Amended 12-17-82

rtificate of Death
STATE OF IDAHO

State File No. 65254
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RU.
Idaho Falls
LENGTH OF STAY (In this place)
d. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION: L.D.S.Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Ucon
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Angelina	Ritchie	Tracy	February 13, 1929

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	Married	Sept. 2, 1885	43	5 / 9	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Ogden, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John James Ritchie	Utah	Harriet Ann Coop	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	-----	W. H. Tracy	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

**This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Cerebro Spinal Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb. 10, 1929, *to* Feb. 12, 1929, *that I last saw the deceased alive on* Feb. 12, 1929, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. M. Cline	M.D.	Idaho Falls, Idaho	Feb. 16, 1929

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Feb. 15, 1929		Iona, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Feb. 16, 1929	Wm. Kinnard	Jack A. Wood	

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME:

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics

RECEIVED
SEP 09 1981
Bureau of Vital Statistics

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

State of _____
County of _____ } ss.

Certificate No. 65254
Date Filed _____

The undersigned does solemnly swear that certain facts on the certificate of Death

for Angelina Copp Tracey (Name on Original Certificate) who died (Was Born, Died, etc.) on Feb 12, 1929 (Date of Event)

in Idaho Falls, Idaho (Place of Event) are erroneous or were omitted:

ITEMS TO BE CORRECTED	FROM	TO
#13 Birthplace of Mother	Payne, Idaho	England
#14 Informant	W. H. Tracey	W. H. Tracy
#15 Filed	2-16-1927	2-16-1929
#16 Death Date	2-12-1929	2-13-1929

Subscribed and sworn to before me this 27 day of August, 1981

Notary Public, Marian C Clayton

Residing at Idaho Falls

My commission expires Nov 20, 1983

(Seal)

X Lester Tracy
Signature of Applicant

X [redacted] Route 7 Box 242
Street Address, City, State
Blackfoot Ida

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Bonneville } ss.

(Must be completed ___)
(Is not necessary X)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 27 day of August, 1981

Notary Public, Marian C Clayton

Residing at Idaho Falls

My commission expires Nov 20, 1983

(Seal)

Angelina Tracy Morrison
Supporting Signature

Box 55 Ucon Idaho 83454
Street Address, City, State

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics

RECEIVED
SEP 09 1981
Bureau of Vital Statistics

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

State of _____ } ss.
County of _____

Certificate No. 65254
Date Filed _____

The undersigned does solemnly swear that certain facts on the certificate of Death

for Angelina Copp Tracey (Name on Original Certificate) who died (Was Born, Died, etc.) on Feb 12, 1929 (Date of Event)

in Idaho Falls, Idaho (Place of Event) are erroneous or were omitted:

ITEMS TO BE CORRECTED	FROM	TO
#2 Name of Deceased	Angelina Copp Tracey	Angelina Ritchie Tracy
#6 Date of Birth	Sept 3, 1886	Sept 2, 1885
#10 Name of Father	John Richie	John James Ritchie
#11 Birthplace of Father	Ucon, Idaho	Utah
#12 Maiden Name of Mother	Nancy Beale	Harriet Ann Coop

Subscribed and sworn to before me this 27 day of August 1984

Notary Public, [illegible]
Residing at [illegible]
My commission expires Nov. 26, 1983
(Seal)

X Lester Tracy
Signature of Applicant
Route 2 Box 242 Blackfoot Ida
Street Address, City, State

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Bonneville

(Must be completed ___)
(Is not necessary X)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 27 day of August 1984

Notary Public, [illegible]
Residing at Iona Idaho
My commission expires Nov 26 1983
(Seal)

Angelina Tracy Mason
Supporting Signature
Box 35 Ucon Idaho 83454
Street Address, City, State

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65254

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 31
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Angelina Copp Tracey

(a) Residence. No. Ucon, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of W.H. Tracey

6. DATE OF BIRTH (month, day and year) September 3, 1886

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
43	5	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House-wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ogden, Utah
(State or country)

PARENTS

10. NAME OF FATHER John Richie
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ucon, Idaho
12. MAIDEN NAME OF MOTHER Nancy Beale.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Payne, Idaho

14. Informant W.H. Tracey
(Address) Ucon, Idaho

15. Filed 2/16, 1927 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 12, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1929, to Feb 12, 1929
that I last saw her alive on Feb 12, 1929
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) ____ yrs. ____ mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? Ucon, Ida
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) [signature] M. D.
Feb 16, 1929 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Iona, Idaho	1929 Feb. 15
20. Undertaker Jack A. Wood	Address Idaho Falls

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65255

PLACE OF DEATH

County of Bonneville Registration District No. 13
City of Idaho Falls Primary Registration District No. 21 Local Registrar's No. 30
(No. L.D.S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Aaron Hoffman.

(a) Residence. No. Jackson Wyo. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
66	0	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown.
12. MAIDEN NAME OF MOTHER: Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: John F. Woodman.
(Address) Jackson Wyo.

15. Filed 2/13, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 10 (Month) (Day) 1929. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1928, to Feb 10, 1928
that I last saw h[illegible]ive on Feb 10, 1928
and that death occurred, on the date stated above, at 9 27 P m.
The CAUSE OF DEATH* was as follows:

Diabetic Gangrene
right foot
3
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Diabetes Mellitus
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Jackson Wyo
Did an operation precede death? No Date of Dec 28-1928
Was there an autopsy?
What test confirmed diagnosis? Clinical
(Signed) [illegible], M. D.
, 19 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Jackson Wyo	Feb 14 1929
20. Undertaker: V. F. McHaus	Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65256

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. C.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 29

2. FULL NAME Fred Reid Helm

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 18 1929.

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
0	0	22.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls. Ida.

PARENTS

10. NAME OF FATHER J. A. Helm.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fort Worth Texas
12. MAIDEN NAME OF MOTHER Maude Pauline Wilson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Grant. Ida.

14. Informant Mrs Maude Pauline W Helm
(Address) Monte View Idaho.

15. Filed 2/12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 12. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11, 1929, to Feb 12, 1929
that I last saw him alive on Feb 11, 1929
and that death occurred, on the date stated above, at 7 A. m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Persistent Thymus

(duration) ..... yrs. ..... mos. – ds.

18. Where was disease contracted if not at place of death? Rigby, Idaho
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H Ray Hatch, M. D.
Feb 12, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grant Idaho. Date of Burial: Feb 13 1929.

20. Undertaker: V. F. McHan. Address: Idaho Falls Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED MAR 21 1929

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65257

County of Bonneville. Registration District No. 13

City of Idaho Falls Primary Registration District No. 21-0

Local Registrar's No. 28

(No. L.D.S. Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wayne Morris.

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 15-1920

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	2	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Neon Idaho

PARENTS

10. NAME OF FATHER Frank Morris

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada.

12. MAIDEN NAME OF MOTHER Ivy Metcalf

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho Falls

14. Informant Frank Metcalf.

(Address) Neon Idaho.

15. Filed 2/12, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1929, to Feb. 9, 1929, that I last saw h~~im~~ alive on Feb. 9, 1929 and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal-Meningitis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Spinal fluid

(Signed) Henry L. Hillson, M. D.

2/11, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Neon Idaho	Feb 12 1929

20. Undertaker	Address
V. F. McHan	Idaho Falls Ida.

Amended Dec. 16, 1982 X

RECEIVED FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
65258
State File No.

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 1970
Local Registrar's No. 27
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME MARY Jane Tracy

(a) Residence. No. (Usual place of abode) Ucon, Idaho St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 21, 1915

7. AGE: Years 13 | Months 7 | Days 19 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ucon, Idaho

PARENTS

10. NAME OF FATHER: W. H. Tracy
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ogden, Utah
12. MAIDEN NAME OF MOTHER: Angelina Pitchie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ogden, Utah

14. Informant: Mrs. W. H. Tracy
(Address) Ucon, Idaho

15. Filed Feb 11, 1929 (Signature) Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 9, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9, 1929, to Feb 9, 1929
that I last saw h[illegible] alive on, 19
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ucon Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [illegible], M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Iona Idaho — Date of Burial: Feb. 12 1929
20. Undertaker: Jack C. Wood — Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

State of _____ } ss.
County of _____ }

MAY 10 8 18 AM '82

Certificate No. 65258
Date Filed 1929

The undersigned does solemnly swear that certain facts on the certificate of death

for Jane Tracy (Name on Original Certificate) who died (Was Born, Died, etc.) on Feb. 9, 1929 (Date of Event)

in Idaho Falls (Place of Event) are erroneous or were omitted:

ITEMS TO BE CORRECTED	FROM	TO
2. Name	Jane Tracy	Mary Jane Tracy
6. Date of birth	June 22, 1915	June 21, 1915
7. Age	13 yrs, 7 mos, 17 days	13 yrs, 7 mos, 19 days
12. Name of mother	Angie Ritchie	Angelina Ritchie

Subscribed and sworn to before me this 15th day of December, 1982

Notary Public, Florence Cartright

Residing at Boise

My commission expires April 20-1986

(Seal)

Roy D. Hill
Signature of Applicant

142 S. PARK SUGAR CITY IDA 83448
Street Address, City, State

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____ } ss.
County of _____ }

(Must be completed __)
(Is not necessary __)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of _____, 19__.

Notary Public, _____

Residing at _____

My commission expires _____

(Seal)

_____
Supporting Signature

_____
Street Address, City, State

10.26 81 ju/ja

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65259

Registration District No. 3
Primary Registration District No. 2-N-D
Local Registrar's No. 26

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vera Heaton

(a) Residence. No. Idaho Falls, Idaho St. (Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) January 23, 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER Vernon Heaton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Portage, Utah
12. MAIDEN NAME OF MOTHER Ella Cleverly
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Shelton, Idaho

14. Informant Mr. Vernon Heaton
(Address) Idaho Falls, Idaho

15. Filed 2/11, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-6, 1929, to 2-9, 1929.
that I last saw h alive on 2-9 1929.
and that death occurred, on the date stated above, at 12-45 p m.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) R D Sutton, M. D.
2-9-, 1929 (Address) Ida Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shelton, Idaho	February 11 1929

20. Undertaker Jack A. Wood Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65260

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 2
Primary Registration District No. 21-2
Local Registrar's No. 2
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clark Watson

(a) Residence. No. Idaho Falls, Idaho. R.F.D.#7. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 23, 1917

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	12	7	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dubois, Idaho

PARENTS

10. NAME OF FATHER Robert S. Watson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Mary Rozlia Messervey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wilford, Utah

14. Informant Robert S. Watson
(Address) Idaho Falls, Idaho R.7.

15. Filed 2/9, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 8, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1929, to Feb. 8, 1929
that I last saw him alive on Feb 8, 1929
and that death occurred, on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:

Small pox
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Acute indigestion
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. A. Lupperle M.D.
, 19 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho	Feb. 9 1929
20. Undertaker	**Address**
Jack A. Wood	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 1/3

DO NOT WRITE IN THIS SPACE
State File No. 65261

Local Registrar's No. 24

PLACE OF DEATH
County of Bonneville.
City of Idaho Falls. Registration District No.
Primary Registration District No. VIII-D
(No. L.D.S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sayer.

(a) Residence. No. Shelly Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 15 - 1928

7. AGE Years	Months	Days	If LESS than 1 day,
0	3	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rigby Idaho.

PARENTS

10. NAME OF FATHER Clarence Sayer.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rigby Idaho
12. MAIDEN NAME OF MOTHER Eleanore Katzmeyer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant Clarence Sayer.
(Address) Shelly Idaho.

15. Filed 2/9, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 8 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1929, to Feb. 8, 1929
that I last saw her alive on Feb. 7, 1929
and that death occurred, on the date stated above, at 5 A. m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Catarrhal enteritis
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of —
Was there an autopsy? No. —
What test confirmed diagnosis? Laboratory.
(Signed) Edwin Cutler M. D.
2-8, 1929 (Address) Shelly Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby Idaho	Feb. 9 1929.
20. Undertaker	Address
W. F. McHan	Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65262

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 21-0
Local Registrar's No. 23
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Lola Kehl
(a) Residence. No. Idaho Falls, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE — Years | Months: 1 | Days: 18 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Salt Lake City, Utah

PARENTS
10. NAME OF FATHER: J. R. Kehl
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Eleanore Moffitt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Grangefield, Utah

14. Informant: J. R. Kehl
(Address) Idaho Falls, Idaho

15. Filed 2/9, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 8 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 6, 1929, to Feb 9, 1929
that I last saw h alive on, 19
and that death occurred, on the date stated above, at 4:30 P.m.
The CAUSE OF DEATH* was as follows:
Acute Dilatation Colitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [illegible], M. D.
, 19 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salt Lake City, Utah	Feb. 11 1929
20. Undertaker: Jack A. Wood	Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65263

Local Registrar's No. 22

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 214-0
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emily Jane Martin

(a) Residence. No. 74 Johnes Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white.	married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 18-1850

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	9	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Council Bluffs, Iowa

PARENTS

10. NAME OF FATHER W. M. Griffin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Elinore Hogborne
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Al. Martin.
(Address) Idaho Falls. Ida.

15. Filed 2/7, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1928, to Feb. 4, 1929
that I last saw h[illegible] alive on Jan. 15, 1929
and that death occurred, on the date stated above, at 11 A. m.
The CAUSE OF DEATH* was as follows:
Gastric Carcinoma
Indefinite
(duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY
(Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John O. Miller M. D.
Feb 4, 1929 (Address) Idaho Falls,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewisville Ida.	Feb. 7 1929
20. Undertaker	Address
V. F. McHan.	Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65265

Registration District No. 73
Primary Registration District No. 2170
Local Registrar's No. 20

PLACE OF DEATH

County of Bingham
City of Kimball
Idaho Falls
L.D.S. Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elda Roanna Annis Frandsen,

(a) Residence. No. Kimball St.
(Usual place of abode)
Length of residence in city or town where death occurred 7 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Baker

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Baker

6. DATE OF BIRTH (month, day and year) 11-25 28

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Kimball Bingham Co. Ida.

PARENTS

10. NAME OF FATHER Illegitimate
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ?
12. MAIDEN NAME OF MOTHER Blenda Roanna Frandsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kimball Idaho

14. Informant Lelle M. Frandsen
(Address) R 1 Firth & Shelley Ida

15. Filed Feb 7, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-20-, 1929, to 1-22-, 1929
that I last saw h[illegible] alive on 1-22, 1929
and that death occurred, on the date stated above, at 11 P.M.,
The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Edwin Cathe, M.D.
11-23-, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Basalt Idaho Rosedale Cemetery — Date of Burial 1-24, 1929

20. Undertaker None — Address —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65266

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2150

Local Registrar's No. 19

(No. L. D. S. Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eunice McAllister

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 3 - 1910

7. AGE Years 19 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work no.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls

PARENTS

10. NAME OF FATHER Chas P McAllister

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Grace E Bean

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Chas P. McCallister
(Address) Idaho Falls Ida.

15. Filed Feb 2, 1929 C M Fernand Registrar
Dr. Chinese

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 31 (Day) 1938 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Jan 31, 1929
that I last saw her alive on Jan 31, 1929
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? lab

(Signed) Cecil Clive, M. D.

....., 19.... (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls — Date of Burial Feb 3 1929

20. Undertaker Cliff C Hayes — Address Idaho Falls

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65267

Local Registrar's No. 14

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2130

(No. 14 A 2A)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Henry Hall

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 1 1848

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER Gordon Fletcher

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Carolyn Hall

(Address) Idaho Falls Ida

15. Filed Mar 22, 1929 W. Turnquist Registrar
D. Evans

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1929, to Jan 31, 1929
that I last saw h[illegible] alive on Jan 31, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) W. W. Allen, M. D.
....., 19..... (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls	Apl 3 1929

20. Undertaker Hoffman & Hayes Idaho Falls Ida | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65268

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21 V-D
(No. C. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

2. FULL NAME Betty Jean Corbett.
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May 16 1927.
7. AGE Years 1 Months 8 Days 15 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho Falls. Ida.

PARENTS
10. NAME OF FATHER Ross Corbett.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Smithfield Utah.
12. MAIDEN NAME OF MOTHER Christine Farney.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bigelow Mo.

14. Informant Ross Corbett.
(Address) Idaho Falls. Ida.
15. Filed Sep 2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 31 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1929, to Jan 31, 1929
that I last saw her alive on Jan. 31, 1929
and that death occurred, on the date stated above, at 8 30 P. m.
The CAUSE OF DEATH* was as follows:
Gastro-enteritis - (Convulsions)
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Bronchitis
..... (duration) ..... yrs. ..... mos. 6 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Harry L. Willson, M. D.
2/2/29, 19.... (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal ~~Smithfield Utah.~~ ~~(Trenton Utah)~~ Date of Burial Feb. 4 1929
20. Undertaker V. F. McHan Address Idaho Falls Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65269

PLACE OF DEATH

County of Canyon
City of 9 mi so Nampa
Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 28
(No. 9 miles so Nampa) Canyon
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joyce June Moore

(a) Residence. No. Nampa R. #4 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of June 9 - 1927.

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	8	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa, Idaho

PARENTS

10. NAME OF FATHER Leo Moore
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Katherine Messer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ore.

14. Informant Mrs. Katherine Moore
(Address) R.F.D. No. 4 Nampa, Ida.

15. Filed 5-5, 1929 Retha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-16, 1929, to 3-3, 1929
that I last saw her alive on 3-3, 1929
and that death occurred, on the date stated above, at 5:20 p.m.
The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Whooping Cough
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas E Mauzy M. D.
3-5, 1929 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	3-5-th 1929
20. Undertaker	Address
Mrs. Nina M. Talley	Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65270

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 29
(No. 787 Fairview Ave)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nicy Cook

(a) Residence. No. 787 Fairview Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 15th 1832

7. AGE	Years	Months	Days	If LESS than 1 day,
	97		19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tennessee.

PARENTS

10. NAME OF FATHER David Attaway
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Mrs. W. C. Hues
(Address) Nampa, Idaho.

15. Filed 3-6, 1929. Stella Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-3, 1929, to 3-4, 1929
that I last saw her alive on 3-4, 1929
and that death occurred, on the date stated above, at 8:20 P. m.
The CAUSE OF DEATH* was as follows:
Heart block

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Senility, Limitation
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Objective Symptoms
(Signed) H C Robinson, M.D.
3-4, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	3-6 1929

20. Undertaker — Address
Mrs. Nina M. Talley — Nampa, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65271

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No.

Primary Registration District No.

Local Registrar's No. 0

(No. 1112 - 6th St. So)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Monroe Farley

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June — 1848

7. AGE: Years 80 | Months 9 | Days unknown | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mass.

PARENTS

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Ralph Monteeth

(Address) Nampa, Idaho

15. Filed , 19 , Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 9th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to March 9, 1929

that I last saw him alive on March 9, 1929

and that death occurred, on the date stated above, at 8:45 P.m.

The CAUSE OF DEATH* was as follows:

Septic infection of arm following injury (Gangrene)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V C Bellinger M. D.

Mar 11, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sargent, Nebraska

Date of ~~Burial~~ Shipment: 3-11 1929

20. Undertaker: Wm D. Talley

Address: Nampa, Ida.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon

City of Melba

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 2006

(No. ..... St.)

State File No. 65272

Local Registrar's No. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Heyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~ Single (Write the word)

6. DATE OF BIRTH: March 1 1929 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many One hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Fred Herget

11. BIRTHPLACE OF FATHER (State or Country): Washington State

12. MAIDEN NAME OF MOTHER: Ines May Montgomery

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Herget
(Address) Melba Idaho

15. Filed 3/1 1929 Bertha Conway
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 1 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to Mar 1 1929 that I last saw him alive on March 1 1929 and that death occurred on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

Prematurely from accidental fall of mother

..... (Duration) ..... yrs. ..... mos. 2 or 3 hours ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo R Proctor M. D.

..... 19..... (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER None | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65273

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 7016
(No. 915-15th Ave. So.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 53

2. FULL NAME Nancy A Bontrager

(a) Residence. No. (Usual place of abode) St. Nampa, Oregon
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of C. M. Bontrager

6. DATE OF BIRTH (month, day and year) July 28-1844

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	7	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Christine Garber
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER Lucy Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Mrs. Bontrager
(Address) Bend, Oregon

15. Filed 3/15, 1929 Estella Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 14th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10, 1929, to March 14, 1929
that I last saw her alive on March 12, 1929
and that death occurred, on the date stated above, at 3:30 P. m.
The CAUSE OF DEATH* was as follows:

Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) W. C. Motte, M. D.
....., 19..... (Address) Nampa,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill, Boise	3-16 1929
20. Undertaker	**Address**
Mrs Nina M. Talley	Nampa, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED APR 9 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. ..... , ... St.)

File No. 65274

Registered No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eldon Nielson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 16th (Day) 1908 (Year)

7. AGE: 20 Yrs. 7 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: E F Nielson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Edna Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Don Poynter

(Address) Nampa Idaho

15. Filed 3/16 1929 Bertha Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1922, to 3-15 1929, that I last saw him alive on 3-15 1929, and that death occurred on the date stated above, at 6:10 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Epilepsy

(Duration) 18 yrs. ..... mos. ..... ds.

(Signed) Don Poynter M. D.

3-15 1929 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 7 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Fairfield Idaho

19. PLACE OF BURIAL OR REMOVAL: Fairfield, Idaho

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Wm D. Talley

ADDRESS: Nampa, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65275

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 45
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Floyd Wm Mitchell

(a) Residence. No. 3 miles So west of Nampa St. Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret

6. DATE OF BIRTH (month, day and year) August 7th

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	7	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER Limandra Chrisman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Margaret Mitchell
(Address) Nampa Idaho.

15. Filed 3/18, 1929 [illegible] County Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-14, 1929, to 3-15, 1929
that I last saw him alive on 3-15, 1929
and that death occurred, on the date stated above, at 12:10 A. m.
The CAUSE OF DEATH* was as follows:
Heartblock
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Subjective Symptoms & history
(Signed) H C Robinson, M. D.
3-16, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill-Caldwell	3-19 1929
20. Undertaker	Address
Wm D. Talley	Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1929

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65276

Registration District No. 7

Primary Registration District No. 2006

Local Registrar's No. 36

(No. Mercy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jessie Marie Jones.

(a) Residence. No. Huston R. 1. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug 8-21

7. AGE: Years 7, Months 6, Days 25; If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nampa. Idaho

PARENTS

10. NAME OF FATHER: G. Jones.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ark.

12. MAIDEN NAME OF MOTHER: Eldora Baren.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Boise. Idaho

14. Informant: Mrs. G. Jones

(Address) R.F.D. #1 Huston, Idaho

15. Filed 3/4, 1929 Bertha Enway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 3rd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1929 to Mar 3, 1929

that I last saw her alive on March 2, 1929

and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis following Mastoid infection

(duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY (Secondary): Chronic ~~mastoid~~ Muddle ear infection

(duration) 3 yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of 2-8-29 and Mar 1-29.

Was there an autopsy?

What test confirmed diagnosis? Opr

(Signed) V C Bellamy M. D.

3-6-, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa

Date of Burial: 3-4 1929

20. Undertaker: Mrs. Nina M. Talley

Address: Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65277

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1116

Local Registrar's No. 33

(No. Mercy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Connell Moss

(a) Residence. No. 523 - 11th Ave So St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sidney Elizabeth Moss

6. DATE OF BIRTH (month, day and year) October 23-1852

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	76	4	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) not known

PARENTS

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant E. Ethel McBane

(Address) 523 - 11th Ave. So. Nampa

15. Filed 3/18, 1929 E. Ethel Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 13th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-5, 1929, to 3-13, 1929

that I last saw him alive on 3-13, 1929

and that death occurred, on the date stated above, at 1-30 P m.

The CAUSE OF DEATH* was as follows:

Duodenal Carcinoma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Duodenal ulcer (duration) 20 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. E. Robinson, M. D.

3-15, 1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	3-15 1929

20. Undertaker Address

Wm. D. Talley Nampa, Ida.

RECEIVED APR 9 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65279

Local Registrar's No. 57

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leonora W Musselter

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married
6. DATE OF BIRTH: Dec (Month) 7 (Day) 1865 (Year)
7. AGE: 63 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Mo.
10. NAME OF Father: Joseph A Walker
11. BIRTHPLACE OF FATHER (State or Country): unknown
12. MAIDEN NAME OF MOTHER: Martha Snodgrass
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R E Musselter
(Address) Nampa Idaho
15.
Filed 19 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 25 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 2-22 1929 to 2-25 1929, that I last saw h alive on 2-25 1929, and that death occurred on the date stated above, at 5:30 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) yrs. mos. 4 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J C Horton M. D.
2-28 1929 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Johnson Lawn Cem. DATE OF BURIAL: 3-1 1929
20. UNDERTAKER: Fred R Brinson ADDRESS: Nampa Ida.

H.

FORM No. 6-76-M 1-29

RECEIVED APR 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65280

Local Registrar's No. 7

1. **PLACE OF DEATH**
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 2006
(No. Mercy Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Robert W. Montgomery

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	single

6. **DATE OF BIRTH** ..... (Month) ..... (Day) 1 (Year)

7. **AGE** 81 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. **BIRTHPLACE** (State or Country): Penn.

10. **NAME OF Father**: James W. Montgomery

11. **BIRTHPLACE OF FATHER** (State or Country): Virginia

12. **MAIDEN NAME OF MOTHER**: Nancy A. Waller

13. **BIRTHPLACE OF MOTHER** (State or Country): Virginia

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) W. Montgomery
(Address) Nampa Ida

15. Filed 3-12 1929 Ruth Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** 3 (Month) 9 (Day) 1929 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Mar 1 1929 **to** Mar 9 1929, **that I last saw him alive on** Mar 9 1929, **and that death occurred on the date stated above, at** 4 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
Valvular heart lesion

(Duration) ? yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. P. Roos M. D.
Mar 10 1929. (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Fairview Cem. **DATE OF BURIAL** 3-13 1929

20. **UNDERTAKER** Fred K. Robinson **ADDRESS** Nampa

Ross.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65281

Local Registrar's No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. 717 - 15 Ave. So St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ananias Neher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Dec. (Month) 15 (Day) 1853 (Year)

7. AGE: 76 Yrs. 21 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Indianna

10. NAME OF Father: Martin Neher

11. BIRTHPLACE OF FATHER (State or Country): Va -

12. MAIDEN NAME OF MOTHER: Simmons

13. BIRTHPLACE OF MOTHER (State or Country): Va -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A. Neher
(Address) 715 - 15th Ave. S. Nampa

15. Filed 3 - 19 1929 Bertha Conway
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-24 1927 to 3-17 1929, that I last saw him alive on 3-17 1929 and that death occurred on the date stated above, at 10 15 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 18 yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Horton M. D.

19 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn

DATE OF BURIAL: March 19 1929

20. UNDERTAKER: F. K. Robinson

ADDRESS: Nampa Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

11-5

RECEIVED APR 9 1929

FORM V. S. No. 6-20 M.-1-19.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State File No. 65282

Local Registrar's No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

(No. 1423 - 9 St. South St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Virginia Mae Manning

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single

6. DATE OF BIRTH: June (Month) 19 (Day) 1925 (Year)

7. AGE: 3 Yrs. 7 Mos. 29 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Glenns Ferry Idaho

10. NAME OF Father: Rupert W. Manning

11. BIRTHPLACE OF FATHER (State or Country): Nampa Idaho

12. MAIDEN NAME OF MOTHER: Fern Wylie

13. BIRTHPLACE OF MOTHER (State or Country): Portland, Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rupert W Manning

(Address) 1423 - 9th St So Nampa Ida

15. Filed 3-21 1929 Retha Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-16- 1929 to 3-17- 1929 that I last saw her alive on 3-17- 1929 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Coma of Brain Tumor

with Hydrocephalus

(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary) Acute Pneumonia Bronchial

(Duration) ....yrs. ....mos. ....ds.

(Signed) Leo K Proctor M. D.

(Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview Cem — DATE OF BURIAL: 3-20 1929

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Proctor

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED APR 9 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7

Primary Registration District No. 1006

File No. 65283

Registered No. 7

1. PLACE OF DEATH

County of Canyon

City of Nampa

(No. State Sanitarium St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Keenan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March (Month) 15 (Day) 1850 (Year)

7. AGE: 79 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Pogue

(Address) Nampa Idaho

15. Filed 3/18 1929

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1918 to March 18 1929 that I last saw him alive on March 18 1929, and that death occurred on the date stated above, at 4:50 M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary) Senile Decay

(Duration) yrs. mos. ds.

(Signed) Dr. Pogue M. D.

3-18-1929 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 10 yrs. 9 mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Emplire Idaho

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn — DATE OF BURIAL: 3/21 1929

20. UNDERTAKER: Fred K. Robinson — ADDRESS: Nampa Ida.

FORM V. S. No. 5-25-M-1-19 RECEIVED APR 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. Mercy Hospital St.)

State File No. 65284

Local Registrar's No. 84

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma L. Givens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: June (Month) 2 (Day) 1858 (Year)

7. AGE: 71 Yrs. 9 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF Father: A. Smith

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Mary J. Huffsmith

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Clint Ford
(Address) Nampa Ida.

15. Filed 3/15 1929 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11, 1929 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 26 1929 to Mar. 11 1929, that I last saw her alive on Mar 11 1929 and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) Myocarditis, Nephritis

(Duration) ..... yrs. 10 mos. ..... ds.

(Signed) Samuel A Swayne M. D.

3/11 1929 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem

DATE OF BURIAL: 3/13/29 19

20. UNDERTAKER: Fred K. Robinson

ADDRESS: Nampa Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65285

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No.
(No. 217-9th ave. No)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bessie Brackett McWethy

(a) Residence. No. 220-9th ave. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Jerome McWethy.

6. DATE OF BIRTH (month, day and year) Dec. 8th 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	67	3	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER — Forder

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Bessie —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Arthur Cadour
(Address) 217-9th ave No. Nampa, Ida

15. Filed 3-31, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-22, 1929, to 3-26, 1929
that I last saw her alive on 3-12, 1929
and that death occurred, on the date stated above, at 10:45 P. m.
The CAUSE OF DEATH* was as follows:

Cystitis
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Inanition,
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) J. C. Horton M. D.
3-29, 1929 (Address) J. C. Horton

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	3-31 1929
20. Undertaker	Address
Mrs. Nina M. Talley	Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65286

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 46

2. FULL NAME Sarah Rinker

(a) Residence. No. 116-10 ave. So
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Rinker

6. DATE OF BIRTH (month, day and year): Feb 15 1867

7. AGE: Years 62, Months 1, Days 6. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10. NAME OF FATHER: William James
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. H.
12. MAIDEN NAME OF MOTHER: Eliza Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ind

14. Informant: Geo Rinker
(Address) 807-1st S.

15. Filed 4-1, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1924, to Feb 21, 1929
that I last saw her alive on Feb 21, 1929
and that death occurred, on the date stated above, at 9:30 a. m.
The CAUSE OF DEATH* was as follows:
(Carcinoma)
Cancer of Stomach
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Preceded by infected gall bladder + chronic appendix (duration) 2 yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Exploratory Date of 1927
Was there an autopsy? No Pathological report
What test confirmed diagnosis? Exploratory operation
(Signed) J H Murray, M. D.
Feb 23, 1929 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kootenai Cem
Date of Burial: 3-24 1929

20. Undertaker: Fred K Robinson
Address: Nampa Ida

Murray

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65287

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No.)
Local Registrar's No. 47

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary L. Hicks

(a) Residence. No. 615-17 Ave So St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 17 - 1863

7. AGE: Years 66 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10. NAME OF FATHER George Wesley Valentine
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Md.
12. MAIDEN NAME OF MOTHER Susan Seaman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virg.

14. Informant Clyde Hicks
(Address) 615-17 Ave So

15. Filed 4-1, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 26 - 27 19 , to Mar. 26 , 19 29
that I last saw h alive on Mar 26 , 19 29
and that death occurred, on the date stated above, at 4 40 m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Cardiac dilitation (duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Samuel A Sway, M.D.
3-27-, 1929 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fairlawn Cem — Date of Burial 19
20. Undertaker: Reed & Stinson — Address: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Arcoyne

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65288

Local Registrar's No. 98

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No.
Primary Registration District No.
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Warren Sanford Johnson

(a) Residence. No. 412 - 13th Ave. So. St.
(Usual place of abode)
Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Myrtle Johnson

6. DATE OF BIRTH (month, day and year) March 28th 1893

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	0	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Telegraphy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Oregon Short Line R.R.

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER J. B. Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Nellie Payne

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Mrs. Nellie Johnson
(Address) Cliftonford, Virginia

15. Filed April 2, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 30, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1929, to March 30, 1929
that I last saw him alive on March, 1929
and that death occurred, on the date stated above, at 6:20 A m.
The CAUSE OF DEATH* was as follows:

Acute endocarditis, and tricuspid insufficiency
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 7 & 10 ds.

18. Where was disease contracted if not at place of death? In Oregon
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. R. Proctor M. D.
April 1, 1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wichita, Kansas	— 19

20. Undertaker	Address
Wm D. Talley	Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-23-M. 1-19 RECEIVED APR 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65289
Local Registrar's No. 49

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1336
(No. 714 - 3rd St. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME ~~Harriet~~ Hattie M. Kinder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH: June (Month) 6 (Day) 1858 (Year)

7. AGE: 71 Yrs. 9 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF Father: Henery L. Bradley

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Phebe A Bell

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Minnie Bradley
(Address) 712 - 3rd St - S.6.

15. Filed 4-4 1929 Dorothy Conway
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1928, to 3 - 14 1929, that I last saw her alive on 3 - 14 1929, and that death occurred on the date stated above, at 8 30 M.P.

The CAUSE OF DEATH* was as follows:
Cancer breast & hemorrhage
(Duration) 2 yrs. mos. ds.
Contributory (Secondary) Cancer breast
(Duration) yrs. mos. ds.
(Signed) Horace P Bellman M. D.
3/7 1929 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 5 mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? Kansas
Former or usual residence Olivet Kansas

19. PLACE OF BURIAL OR REMOVAL: Kohlenlawn Cem
DATE OF BURIAL: 3-18 1929

20. UNDERTAKER: Fred K. Robinson
ADDRESS: Nampa Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

H. P. B.

FORM V. S. No. 5-25 M-1-19

RECEIVED APR 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65290

Local Registrar's No. 2-31

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 2006

(No. Mercy Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John E Grover

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widower

6. DATE OF BIRTH: Dec (Month) 21 (Day) 1834 (Year)

7. AGE: 94 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer): (Retired)

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF Father: Drew Grover

11. BIRTHPLACE OF FATHER (State or Country): Conn

12. MAIDEN NAME OF MOTHER: Debora Norris

13. BIRTHPLACE OF MOTHER (State or Country): Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John E. Grover Jr.

(Address) Melba, Idaho

15. Filed 3-20 1929 Tertha Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1929, to Mar 17 1929, that I last saw him alive on March 16 1929, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 14 ds.

Contributory (Secondary) Arteriosclerosis

(Duration) several yrs. mos. ds.

(Signed) V C Boyle M. D.

3-25 1929 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Melba Cem — DATE OF BURIAL: 3-20 1929

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V C B.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65292

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1106
Local Registrar's No. 52
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jefferson M. Waterhouse

(a) Residence. No. 136 Elmore ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 20 1856

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Portland, Me

PARENTS

10. NAME OF FATHER Gardner Waterhouse

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maine

14. Informant Mrs J.M. Waterhouse
(Address) Nampa, Ida.

15. Filed 4-1, 1929 Martha Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 31 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from (Jan. 14 —, 1929, to Mar 31, 1929
that I last saw h[illegible] alive on Mar. 31, 1929
and that death occurred, on the date stated above, at 11 m.
The CAUSE OF DEATH* was as follows:
Cerebral Embolus
following operation.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Mar. 21-1929
Was there an autopsy? No
What test confirmed diagnosis? Clinical signs
(Signed) Samuel A Swaney M. D.
4/1/29, 19 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem.	4/2/29 19

20. Undertaker	Address
Fred K. Robinson	Nampa Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65293

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 55
(No. 324 - 13th Ave. So.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John P. Riesser

(a) Residence. No. 324 - 13th Ave So St.
(Usual place of abode)
Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Phoebe Riesser.

6. DATE OF BIRTH (month, day and year) March 13th 1853

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	~~10~~	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Delaware County Indiana

PARENTS

10. NAME OF FATHER Christian Riesser

11. BIRTHPLACE OF FATHER (city or town) (State or Country) France.

12. MAIDEN NAME OF MOTHER Barbara Zimmerman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs. Lee Lantz
(Address) Nampa, Idaho.

15. Filed 4-1, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 23rd 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-13, 1928, to 3-23, 1929, that I last saw him alive on 3-23, 1929, and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Arteriosclerosis

Coronal yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

Senile (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Symptomatic

(Signed) H E Robinson, M. D.

3-25, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	3-27 1929

20. Undertaker Wm. D. Talley Address Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65294

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 26

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Willard C. Jasper

(a) Residence. No. BX 513 Caldwell, Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Mrs. Lida Jasper

6. DATE OF BIRTH (month, day and year) Jan 19" 1879

7. AGE Years 50 Months 2 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cove Oregon

PARENTS

10. NAME OF FATHER Merle Jasper

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Emma J. Rinhardt

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known.

14. Informant R. W. Jasper

(Address) Halfway Oregon.

15. Filed 4-3-, 1929- John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 1- (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14, 1929, to April 1, 1929

that I last saw him alive on April 1, 1929

and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Parenchymatous nephritis

(duration) two yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyorrhea, (formerly rachitis) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? none Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) C. R. Wittenberger M. D.

Apr. 3, 1929 (Address) Caldwell

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill. Date of Burial: April 3 1929

20. Undertaker: C. V. Peckham Address: Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65295

PLACE OF DEATH*

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 25

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Louise Stone

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Haymond Ward Stone

6. DATE OF BIRTH (month, day and year)

7. AGE 73 Years 9 Months 18 Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Johnathan Finney

11. BIRTHPLACE OF FATHER (city or town) (State or Country): OHio

12. MAIDEN NAME OF MOTHER: Agnes Bevaus

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Harold W Stone
(Address) Boise, Idaho

15. Filed 3-30-, 1929. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to March 28, 1929

that I last saw her alive on March 28, 1929

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary): Parenchymphritis

..... (duration) 1+ yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S R Hurley, M. D.

3/29, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill Cemetery — Date of Burial: March 30 1929

20. Undertaker: Paul L. Case — Address: Caldwell Ida.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65296

PLACE OF DEATH
County of Canyon
City of Huston

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 24

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank E. Crendorf

(a) Residence. No. Huston. Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Francis E. Crendorf.

6. DATE OF BIRTH (month, day and year) Aug 1855

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Hugh Olives
(Address) Huston Idaho

15. Filed 3-28-, 1929. John L. Meyer. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——, 19—, to —, 19—
that I last saw h— alive on ——, 19—
and that death occurred, on the date stated above, at 5-30 P. m.,
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Agr —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History
(Signed) S. T. Reveller, M. D.
3-28, 1929 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill.	3/28 1929
20. Undertaker C. V. Peckham	Address Caldwell Ida.

Spring 2:30 PM

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 9 [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65298

Local Registrar's No. 22

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cleora Louise Stang

(a) Residence. No. Farmers Ida St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 21-1915

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
13	& 5	-29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Star (State or country) Idaho

PARENTS

10. NAME OF FATHER John Stang

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn.

12. MAIDEN NAME OF MOTHER Bessie Ulen

13. BIRTHPLACE OF MOTHER (city or town) Fort Benton (State or Country) Mont

14. Informant John Stang

(Address) Farmers, Idaho.

15. Filed 3-23-, 1929- John S. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 20 1929

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14, 1929, to March 21, 1929 that I last saw her alive on March 21, 1929 and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Her home, Roosevelt Ida

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms only

(Signed) [illegible], M. D.

3/21, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	3-24-, 1929

20. Undertaker C. V. Beckham Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65300

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 20
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME M. A. Maxfield
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Nov 11-1876

7. AGE: 42 Years | Months: 4 | Days: 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): dont know
(c) Name of employer: dont know

9. BIRTHPLACE (city or town) (State or country): Rifle Colo.

PARENTS

10. NAME OF FATHER: Abram W. Maxfield
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Summerside P.E.I. Canada
12. MAIDEN NAME OF MOTHER: Flora Ann Ramsay
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Summerside P.E.I. Canada

14. Informant: Roy D Maxfield
(Address): Carbondale Colo.

15. Filed 3-21-, 1929. John S. Meyer - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3, 1929, to March 15, 1929
that I last saw him alive on March 14, 1929
and that death occurred, on the date stated above, at 1030P m.
The CAUSE OF DEATH* was as follows:
Endocarditis
..... (duration) several yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Mg Kuts
..... (duration) ..... yrs. 3 mos. ..... ds.

18. Where was disease contracted if not at place of death? Dont know
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none except symptoms
(Signed) [signature], M. D.
3/21, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill | Date of Burial: 3-21 1929

20. Undertaker: C. V. Peckham | Address: Caldwell Ida

RECEIVED APR 9 192[redacted]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65301

PLACE OF DEATH
County of Canyon
City of Wilder

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 19
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Douglas E. Farley
(a) Residence. No. Wilder Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Oct 29-1927
7. AGE Years 1 Months 4 Days 15 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Wilder Idaho.

PARENTS
10. NAME OF FATHER Faris J. Farley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn.
12. MAIDEN NAME OF MOTHER Elizabeth Martin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Faris J Farley
(Address) Wilder Idaho.
15. Filed 3-14-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 14 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Did not treat this [illegible], 19..., to ..., 19...
that I last saw h..... alive on ..., 19...
and that death occurred, on the date stated above, at 10:30 a.m.
The CAUSE OF DEATH* was as follows: Child was attended by Christian Science. Cause of death unknown. Probably whooping cough
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. .....
18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [illegible] M.
3/24, 1929 (Address) Health Space Caldwell

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Roswell
Date of Burial: 3-16 1929
20. Undertaker: C. N. Peckham
Address: Caldwell Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65302

Local Registrar's No. 18

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William McClellan Stitzel.

(a) Residence. No. 1015 Albany St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day,
—	—	—	1-20 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell Ida
(State or country)

PARENTS

10. NAME OF FATHER W. B. Stitzel
11. BIRTHPLACE OF FATHER (city or town) Bellingham Wash.
(State or Country)
12. MAIDEN NAME OF MOTHER Nevada Lammey
13. BIRTHPLACE OF MOTHER (city or town) Nebraska
(State or Country)

14. Informant W.B. Stitzel
(Address) Caldwell Ida

15. Filed 3-12-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 9 — 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9, 1929, to March 9, 1929
that I last saw him alive on March 9, 1929
and that death occurred, on the date stated above, at 10-45 P.M.

The CAUSE OF DEATH* was as follows:
accidental Fall
(duration) yrs. 30 Minutes mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. C. Whittenberger, M.D.
Mar 10, 1929 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	3-11 1929
20. Undertaker G. W. Peckham	Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
65303
State File No.

PLACE OF DEATH

County of Caribou

City of Soda Springs

Registration District No. 82

Primary Registration District No.

Local Registrar's No. 5

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Italo C. Dalsoglio

(a) Residence. No. Rupert St. Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jany 4 - 1904

7. AGE

Years	Months	Days	If LESS than 1 day,
25	2	23	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Central City Colo.

PARENTS

10. NAME OF FATHER Ernesto Dalsoglio

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy

12. MAIDEN NAME OF MOTHER Perina Leoni

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant A. D. Dal Soglio
(Address) Rupert Idaho

15. Filed 3-7-, 1929 Dr Russell Tyrrell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1928, to March 7, 1929
that I last saw h- alive on March 7, 1929
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) 0

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 2-26-29
Was there an autopsy? 0.
What test confirmed diagnosis? X-Ray Stone College
(Signed) Russell Tyrrell, M. D.
3-7-, 1929 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rupert Idaho	3-11- 1929
20. Undertaker C. L. Whitman	Address Soda Springs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65304

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

2. FULL NAME Lorette Shelp
(a) Residence. No. Soda Springs Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
(or) WIFE of Leon E. Shelp.

6. DATE OF BIRTH (month, day and year) Dec 7 - 1879

7. AGE Years 49 Months 3 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Springs Colo.

PARENTS
10. NAME OF FATHER Thos. Coppard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Josephine Curin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dubuque Iowa

14. Informant Pearl J Coppard
(Address) Soda Springs Idaho

15. Filed 3-11-, 1929 M. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec, 1928, to March 10, 1929
that I last saw her alive on March 9, 1929
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:
Organic Heart Disease
(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? 0 Date of
Was there an autopsy? 0
What test confirmed diagnosis? Physical Examination
(Signed) Eric Kirkley, M. D.
3-12-, 1929 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida
Date of Burial 3-12- 1929

20. Undertaker C. D. Whitman
Address Soda Springs

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65305

PLACE OF DEATH

County of Cassia
City of Yale

Registration District No. 119
Primary Registration District No. Yale - 2198 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Alma Sanders

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida.

PARENTS

10. NAME OF FATHER Charles Sanders

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Arizona

12. MAIDEN NAME OF MOTHER Gladys Brown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wachington

14. Informant Lee W. Sanders
(Address) Idahome Idaho

15. Filed Apr 10, 1929 C. R. Sater Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No, 19..., to No, 19...
that I last saw him alive on March 20, 1929
and that death occurred, on the date stated above, at 4 a. m.
The CAUSE OF DEATH was as follows:

Cerebro Spinal Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) C. R. Sater, M. D.
Apr 10, 1929 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Mar 22 1929
20. Undertaker	Address
D. C. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65306

County of Cassia

City of Malta

Registration District No. 119

Primary Registration District No. 2198

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sallie Edmondson Montgomery

(a) Residence. No. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James F Montgomery

6. DATE OF BIRTH (month, day and year) June 4 1843

7. AGE	Years	Months	Days	If LESS than 1 day,
	85	9	10	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scott Co Vaannil Ind.

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant A. W. Montgomery

(Address) Salt Lake City Ut.

15. Filed Apr 10, 1929 C. A. Bales Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 21 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1929, to March 21, 1929

that I last saw h[er] alive on March 15, 1929

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows: Valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. A. Bales M. D.

Apr 10, 1929 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Malta Ida	May 23 1929
20. Undertaker D. C. Johnson	Address Burley

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65307

PLACE OF DEATH
County of Cassia
City of Albion

Registration District No. 119
Primary Registration District No. 2198
Local Registrar's No.
(No. 2)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nathaniel Leavitt

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Minerva Linn Leavitt

6. DATE OF BIRTH (month, day and year) Oct 5, 1849

7. AGE: Years 79 | Months 4 | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: Nathaniel Leavitt
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Amanda Wilson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Mrs. J. S. Powers
(Address) Burley Ida

15. Filed Apr 10, 1929 C. A. Slater Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 2, 1927 to Feb 5, 1929
that I last saw him alive on Feb 2, 1929
and that death occurred, on the date stated above, at 7 A m.
The CAUSE OF DEATH* was as follows: Mitral Regurgitation

(duration) 1 yrs. 11 mos. 28 ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. A. Slater M. D.
3/4, 1929 (Address) Malta, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal: Albion Ida. — Date of Burial: Feb 8 1929
20. Undertaker: D. E. Johnson — Address: Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65308

PLACE OF DEATH

County of Caria

City of Almo

Registration District No. 119

Primary Registration District No. 2198

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lillian Simpson

(a) Residence. No. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Clement Simpson

6. DATE OF BIRTH (month, day and year) Nov. 3, 1905

7. AGE	Years	Months	Days	If LESS than 1 day,
	23	3	24	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Goat Utah

PARENTS

10. NAME OF FATHER Charles B Tracy

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Celestia Chadwick

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bear Co Ida

14. Informant Clement Simpson

(Address) Almo Idaho

15. Filed Apr 10, 1929 C. F. Slater Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 27 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19, 1929, to Feb 27, 1929

that I last saw her alive on Feb 27, 1929

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows: Intestinal Influenza

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) C. F. Slater, M. D.

3/4, 1929 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Goat	Mar. 3 1929
20. Undertaker	Address
W. C. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65309

PLACE OF DEATH

County of Cassia

City of Malta

Registration District No. 119

Primary Registration District No. 2198

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leo Samuel Shill

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 8, 1929

7. AGE — Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Malta Idaho

PARENTS

10. NAME OF FATHER: Jesse Samuel Shill
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Bountiful Utah
12. MAIDEN NAME OF MOTHER: Margaret Luella Duncan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Centerville Utah

14. Informant: L. S. Shill
(Address): Malta Ida.

15. Filed Apr 10, 1929 C. E. Sater Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. 10 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8, 1929 to March 10, 1929
that I last saw him alive on March 10, 1929
and that death occurred, on the date stated above, at 1:30 A m.
The CAUSE OF DEATH* was as follows:
Atelectasis
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Surgical
(Signed) C. E. Sater, M. D.
March 14, 1929 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Malta Ida — Date of Burial: Mar. 11 1929

20. Undertaker: D. E. Johnson — Address: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65310

PLACE OF DEATH

County of Cassia
City of Burley

Registration District No. 117
Primary Registration District No. 296

Local Registrar's No. 11

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Verna Larue Lund

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Raymond Lund

6. DATE OF BIRTH (month, day and year) June 5 1898

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	8	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Brigham City
(State or country) Utah

PARENTS

10. NAME OF FATHER Lars Hansen

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Denmark

12. MAIDEN NAME OF MOTHER Amy Marie Andersen

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Utah

14. Informant Raymond Lund
(Address) Lynn Utah.

15. Filed Feb 21 1929 Dr F H Cutler Registrar
Mrs Greco

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7th, 1929, to Feb 7th, 1929
that I last saw her alive on Feb 7th, 1929
and that death occurred, on the date stated above, at 6-30 a. m.

The CAUSE OF DEATH* was as follows: Hemoptysis probably pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

..... (duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Lynn, Utah

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. E. Nielson, M. D.

2/7, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Brigham City Ut.	Feb 10 1929

20. Undertaker	Address
D. E. Johnson	Burley.

RECEIVED APR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65311

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 36
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dan Long

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Singl

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	60	-		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Irland

PARENTS

10. NAME OF FATHER John Long
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Irland
12. MAIDEN NAME OF MOTHER 3
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) 3

14. Informant W. A. Shaw Coroner
(Address) Orofino

15. Filed Mar 18, 19 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at About 3 PM
The CAUSE OF DEATH* was as follows:

Valvar Heart Dease found dead in bed at Hotel

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. A. Shaw Coroner, M. D.
3/18, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Mar 19 19

20. Undertaker	Address
W. A. Shaw	Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65312

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 32

2. FULL NAME Dolores Iola Crumpaker

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Feb 3- 1929

7. AGE Years | Months 1 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer: ✓

9. BIRTHPLACE (city or town) (State or country): Orofino Idaho

PARENTS

10. NAME OF FATHER: Boyd Emmet Crumpacker
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Big George Idaho
12. MAIDEN NAME OF MOTHER: Iola May Wallace
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Donalda- Canada

14. Informant: Mrs Harry Wallace
(Address) Orofino Idaho

15. Filed Mar 9, 1929 Dep. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 7th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3rd, 1929, to March 6th, 1929
that I last saw her alive on March 6th, 1929
and that death occurred, on the date stated above, at 11:15 p.m.
The CAUSE OF DEATH* was as follows:
Pneumonia =

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary): Measleas = Flu =

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? same
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) W. R. Robertson, M. D.
3/7, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino Ida | Date of Burial: Mar 9- 1929

20. Undertaker: Harry Wallace | Address: Orofino Ida

RECEIVED APR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65313

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 34

2. FULL NAME Otto Oswal Smith Jr
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) ✓

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) 3-13-29

7. AGE Years | Months | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Orofino Idaho

PARENTS
10. NAME OF FATHER Otto Oswal Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Christina Creyland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Alsace

Informant Otto Smith Sr
(Address) Orofino Idaho

15. Filed 3/ 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 14th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-12, 1929, to 3-14, 1929
that I last saw him alive on 3-13, 1929
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:
Malnutrition and inanition
..... (duration) ..... yrs. ..... mos. 14 ds.
CONTRIBUTORY (Secondary) Probably Epileptic spasms
..... (duration) ..... yrs. ..... mos. 14 ds.

18. Where was disease contracted if not at place of death? same
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) J. H. Robertson, M. D.
3/14, 1929 (Address) Orofino Ide

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino | Date of Burial: Mar 15 1929
20. Undertaker: W. A. C[illegible] | Address: Orofino

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65314

PLACE OF DEATH

County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2157
Local Registrar's No. 25
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Geo A Bisson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 6 1909

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	3	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Clearwater Timbe Co

9. BIRTHPLACE (city or town) (State or country) Ida

PARENTS

10. NAME OF FATHER John Bisson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Can
12. MAIDEN NAME OF MOTHER L Lamcard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Can

14. Informant Willian Bisson
(Address) Orfino

15. Filed Mar 16, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1929, to Mar. 15, 1929, that I last saw h alive on Mar. 15, 1929, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Meningitis epidemic
Cerebro spinal-
(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Spinal puncture

(Signed) L. L. Hopkins, M. D.
3/16, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Ground Alone	

20. Undertaker	Address
W. A. Shaw	Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-2[illegible] RECEIVED APR 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Mt Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34

Primary Registration District No. 2020

(No. ..... St.)

File No. 65315

Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Anne O'Rourke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 8 (Day) 1870 (Year)

7. AGE: 58 Yrs. 8 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Millward

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Wrathall

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF [illegible] KNOWLEDGE

(Informant) Mike O'Rourke

(Address) Mt Home

15. Filed Apr 11 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12 1929, to Jan. 16 1929 that I last saw her alive on Jan 10 1929 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Diabetes gaurene, blood poisoning (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) O. P. Hamilton M. D.

1-17 1929 (Address) Mtn Home, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Mt Home

DATE OF BURIAL: Jan 19 1929

20. UNDERTAKER: G. C. Zacher

ADDRESS: Mt Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-

RECEIVED APR 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 65316
Registered No. 2

1. PLACE OF DEATH

County of Elmore
City of Mountain Home (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrus Helix Beach

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: June (Month) 2 (Day) 1871 (Year)

7. AGE: Yrs. 57 Mos. 7 ds. 20

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberyard
(b) General nature of industry, business or establishment in which employed (or employer): Helper

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Andrus Beach

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Hannah Cordingley

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Georgia K. Bennett
(Address) 901 Harrison Blvd Boise Idaho

15. Filed Apr 11 1929 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw him ~~alive~~ on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Killed when struck by freight train at RR Crossing at Mountain Home

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Automobile accidents
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Grant E. Hughes Coroner M. D.
1-23 1929 (Address) Glenns Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain Home	1-25-1929
20. UNDERTAKER	**ADDRESS**
G. C. Zacher	Mt Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

ERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. RECEIVED APR 1 [illegible]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Mt Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34

Primary Registration District No. 2020

(No. ..... , ... St.)

File No. 65317

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo Washington Hammond.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: Oct (Month) 2 (Day) 1860 (Year)

7. AGE: 68 Yrs. 4 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Sheepman

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Benjiman Hammond

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Lucy Hobach.

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John F. Gaines

(Address) Mt-Home

15. Filed April 11 1929

[signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1927, to Feb. 3 1929, that I last saw him alive on Feb. 3 1929, and that death occurred on the date stated above, at 8-40 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis - Sclerosis of coronary artery of heart. Chronic Asthma with emphysema of lungs.

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic gastritis and Enteritis

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) O. P. Hamilton M. D.

2-11 1929 (Address) Mountain Home Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Mt Home

DATE OF BURIAL: Feb. 7 1929

20. UNDERTAKER: G. C. Zacher

ADDRESS: Mt Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-[illegible] RECEIVED APR 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Mt Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34

Primary Registration District No. 2020

(No. ..... , ... St.)

File No. 65318

Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Abe House.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7. AGE: about 76 yrs. Yrs. Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Apr 11 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-25 1929, to 2-9 1929 that I last saw him alive on 2-9 1929 and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows: Carcinoma, Stomach, pylorus and of intestines.

(Duration) Several yrs. ..... mos. ..... ds.

Contributory (Secondary) Hemorrhage from intestines (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) O. P. Hamilton M. D.

2-11 1929 (Address) Mtn Home, Idg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Mt Home. DATE OF BURIAL: Feb 11 1929.

20. UNDERTAKER: G. S. Zacher ADDRESS: Mt Home

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5 RECEIVED APR 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 65319
Registered No. 5

1. PLACE OF DEATH

Registration District No. 34
Primary Registration District No. 2020

County of Elmore
City of Mt Home (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Louise Heath

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	married

6. DATE OF BIRTH: July (Month) 7 (Day) 1879 (Year)

7. AGE: 49 Yrs. 7 Mos. 19 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Charles P Davey

11. BIRTHPLACE OF FATHER (State or Country) Cornwall England

12. MAIDEN NAME OF MOTHER Louise J Rowe

13. BIRTHPLACE OF MOTHER (State or Country) Cornwall England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. S. Heath
(Address) Mt. Home

15. Filed April 11 1929 — H. H. Anderson, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 7 1929 to 2-26-1929 that I last saw her alive on 2-23-1929, and that death occurred on the date stated above, at 7:10 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis

(Duration) 1½ Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J E Emms M. D.
2-28 1929 (Address) Mt Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Home	Feb 28 1929
20. UNDERTAKER	**ADDRESS**
G. C. Sackett	Mt Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 12 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 65320
Registered No. 6

1. PLACE OF DEATH

County of Elmore
City of Mt Home
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clowzo W. Kaler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: December 31 1851 (Month) (Day) (Year)

7. AGE: 77 Yrs. 2 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: George W. Kaler

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Adeliza Barnes

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Georgia K. Bennett.
(Address) 901 Harrison Blvd. Boise Ida

15. Filed April 11 1929
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 9 1929. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-24 1929, to 3-9 1929
that I last saw him alive on 3-9 1929
and that death occurred on the date stated above, at 7.15 P.M.

The CAUSE OF DEATH* was as follows:
Hemorrhage left fissure of Rolando -
Paralysis - right side body left face
(Duration) ..... Yrs. ..... mos. 13 ds.
Contributory (Secondary) Arteriosclerosis -
(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) O. B. Hauptton M. D.
3-12 1929 (Address) Mtn Home Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Mt. Home. DATE OF BURIAL: 3-12 1929.

20. UNDERTAKER: G. S. Zaeler. ADDRESS: Mt Home.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED APR 4 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65321

Local Registrar's No.

1. PLACE OF DEATH
County of Elmore
City of Glenns Ferry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 35
Primary Registration District No. 2021
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Washington Blaser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH: October 18 1911 (Month) (Day) (Year)

7. AGE: 17 Yrs. 5 Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF Father: Henry Louis Blaser

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Addie McClellan

13. BIRTHPLACE OF MOTHER (State or Country): Swan Lake Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Henry Louis Blaser
(Address): Glenns Ferry Idaho

15. Filed 3-25 1929 Mrs Mary Sullivan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 24 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 22 1929, to March 24 1929, that I last saw him alive on March 24 1929, and that death occurred on the date stated above, at 6:45 A M.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
Epidemic
(Duration) ..... yrs. ..... mos. 3 ds.
Contributory Infection
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Davis M. D.
3.25. 1929. (Address) Glenns Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry Ida. DATE OF BURIAL: 3/25 1929

20. UNDERTAKER: G.C. Pucher ADDRESS: Mtn. Home Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65322

PLACE OF DEATH
County of Franklin
City of Preston Idaho

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Jenet Naef

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: whita
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 3 1929

7. AGE Years Months 2 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) BABE
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston

PARENTS

10. NAME OF FATHER J.I.Naef
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mapleton Idaho
12. MAIDEN NAME OF MOTHER Florence Becksetead
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Preston Idaho

14. Informant J.I.Naef
(Address) Preston Idaho

15. Filed , 19 . [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-2, 1929, to 3-4, 1929
that I last saw her alive on 3-4, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Haematophillia
Neonatorum.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) E S Milford M. D.
3-5, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho
Date of Burial: Mar 7 192 19

20. Undertaker: M.W.Hendricks
Address: Preston Ida

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65323

PLACE OF DEATH

County of Franklin
City of Weston
Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Wm. Heusser

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Heusser

6. DATE OF BIRTH (month, day and year) May 15 1847

7. AGE	Years	Months	Days	If LESS than 1 day,
	81	9	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10. NAME OF FATHER Henry Heusser
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Ann Apeickh
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Raymond Heusser
(Address)

15. Filed , 19 . Weston Idaho
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2, 1929, to Feb 26, 1929, that I last saw him alive on Feb 26, 1929, and that death occurred, on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:
Diabetes
(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Febling
(Signed) Thos B Holden, M. D.
27 Feb, 1929 (Address) Preston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Weston Idaho	Mar 2
20. Undertaker	Address
M. W. Hendricks	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65324

PLACE OF DEATH

County of Franklin

City of Franklin

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Brook Scarbrough

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Isabell Scarbrough

6. DATE OF BIRTH (month, day and year) Sept II 1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	5	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER John S. Scarbrough

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Brook

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs. ANN Peterson
(Address) Salt Lake City Utah

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-2, 1929, to 3-2, 1929
that I last saw h alive on dead 3-2, 1929
and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. W. Steele, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Franklin Idaho	Mar 6 29

20. Undertaker M. W. Hendricks Address preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D APR 8 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65325

County of Franklin

City of Mapleton

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Zoay Martha Long

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 3 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	9	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9. BIRTHPLACE (city or town) Mississippi
(State or country)

PARENTS

10. NAME OF FATHER Mechack Holeman

11. BIRTHPLACE OF FATHER (city or town) Miss.
(State or Country)

12. MAIDEN NAME OF MOTHER Martha Holeman

13. BIRTHPLACE OF MOTHER (city or town) Miss.
(State or Country)

14. Informant Rufus Long

(Address) Mapleton Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-29, 1928, to 3-5, 1929, that I last saw h[illegible] alive on 1-3, 1929, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A R Neeley, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mapleton Idaho	Mar 7 28 19

20. Undertaker M.W.Hendricks Address Preston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65326

PLACE OF DEATH
County of Franklin
City of Offord

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Laura Lucile Carpenter

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	3	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Weiser, Idaho.

PARENTS

10. NAME OF FATHER A. W. Carpenter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Commonwealth, Miss.
12. MAIDEN NAME OF MOTHER Ora Clemons
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Offord, Idaho.

14. Informant A. W. Carpenter
(Address) Offord Idaho.

15. Filed , 19 Registrar R. R. Cutler

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14, 1929, to Mar 15, 1929
that I last saw her alive on Mar 15, 1929
and that death occurred, on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Acute Meningitis
(Organism Undetermined)
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Bronchitis
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) Eugene Hooley M. D.
Mar 15, 1929 (Address) Preston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Offord	Mar. 17, 1929
20. Undertaker	Address
M. W. Hendricks	Preston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65328

PLACE OF DEATH

County of Franklin
City of Preston
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Dewalton Stephenson Kofoed

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 24 1927

7. AGE: 1 Years | 10 Months | 29 Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Preston Idaho

PARENTS

10. NAME OF FATHER: Ornold Q Kofoed
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Weston Idaho
12. MAIDEN NAME OF MOTHER: Etna Stephens
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Preston Idaho

14. Informant: Ornald Q Kofoed
(Address): Preston Idaho

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 13, 1929, to Mar 23, 1929
that I last saw him alive on Mar 23, 1929
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Digestive disturbance
9 weeks (duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? ~
Did an operation precede death? No Date of ~
Was there an autopsy? No
What test confirmed diagnosis? Spinal puncture
(Signed) Geo. W. Stokes, M. D.
Mar 24, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho | Date of Burial: Mar 26 19

20. Undertaker: M. W. Hendricks | Address: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65329

PLACE OF DEATH
County of Fremont
City of Ashton

Registration District No. 102
Primary Registration District No. 6
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Joseph Chambers
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): —
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) 2-10-29
7. AGE Years Months Days 1 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ashton Idaho

PARENTS
10. NAME OF FATHER George Chambers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salina Utah
12. MAIDEN NAME OF MOTHER Louise Perry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant George Chambers
(Address) Ashton Idaho

15. Filed 2-12-, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Home, 19, to Home, 19
that I last saw him alive on 19
and that death occurred, on the date stated above, at 5-A.M. m.
The CAUSE OF DEATH* was as follows: Premature (6½ months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
2-12-, 1929 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashton Idaho
Date of Burial: 2-12 1929
20. Undertaker: [signature]
Address: Ashton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65330

Registration District No. 6
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Gem
City of Emmett
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles M. Redfield

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day,
58	—	—	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Civil Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Frank Knox
(Address) Emmett Idaho

15. Filed 3/20, 1929 J. A. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to at death only
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Apoplexia
probably Cerebral Hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) do not know
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. A. Reynolds, M. D.
3/20 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Albany Oregon	
20. Undertaker	Address
C. D. Buckmeun	Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 6 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24

Primary Registration District No.

(No. , St.)

File No. 65331

Registered No. 123

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Evelyn May Middleswarth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: March (Month) 1 (Day) 1929 (Year)

7. AGE: Yrs. Mos. 10 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Everett Middleswarth

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Elina J. King

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Everett W. Middleswarth
(Address) Gooding Idaho.

15. Filed 4-1-1929 J. A. Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1929, to March 10 1929
that I last saw her alive on March 10 1929
and that death occurred on the date stated above, at 1:10 a M.
The CAUSE OF DEATH* was as follows:
Melena

(Duration) Yrs. mos. 10 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Houston E Snyder M. D.
3-1 1929 (Address) Houston E Snyder

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

APR 6 1929

FORM V. S. No. 5-95 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 65332

Registered No. 122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24

Primary Registration District No.

(No. , St.)

2. FULL NAME James Lee Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: July (Month) 24 (Day) 1864 (Year)

7. AGE: 64 Yrs. 9 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. W. Jones (Son)

(Address) Gooding Idaho

15. Filed 4-1- 1929 J H Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16 1929, to March 2 1929, that I last saw him alive on March 2 1929, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C Russell Wear M. D.

3-23 1929 (Address) Gooding Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

APR 11 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Cottonwood

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105

Primary Registration District No. 2183

(No. ..... St.)

File No. 65333

Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary McHugh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) ~~Widowed~~ Married

6. DATE OF BIRTH: April (Month) 5 (Day) 1 (Year)

7. AGE: 59 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas McHugh

(Address) Cottonwood Idaho

15. Filed Mar. 30 1929 W. F. Orr per DB Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) ~~18~~ 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-18 1929 to 3-18 1929 that I last saw her alive on 3-18 1929 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows: Preoperative obstruction of bowel

..... (Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) Ruptured appendix, 2 yrs previous

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.

3/18 1929 (Address) Cottonwood Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Idaho

DATE OF BURIAL: 3/20 1929

20. UNDERTAKER: Vassar Marlowe

ADDRESS: Cottonwood

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19 RECEIVED APR 11 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Cottonwood

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105

Primary Registration District No. 2183

(No. ....., ... St.)

File No. 65334

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Horatio Cook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb 1 1872 (Month) (Day) 1 (Year)

7. AGE: 57 Yrs. 1 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Hotel Manager

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Alexander Cook

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice E. Cook

(Address) Cottonwood Idaho

15. Filed Mar. 30 1929 W. F. Ouri per D.B. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11 1929, to Mar 13 1929, that I last saw him alive on Mar 13 1929, and that death occurred on the date stated above, at 5:15 a. M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. A. Woodcock M. D.

..... 19..... (Address) Cottonwood Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston

DATE OF BURIAL: 3/18 1929

20. UNDERTAKER: Brower and Warner

ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. RECEIVED APR 11 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 65335
Registered No. 2

1. PLACE OF DEATH

County of Idaho
City of Cottonwood (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sophia Kaus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Dec (Month) 3 (Day) 1850 (Year)

7. AGE: 78 Yrs. 3 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Weitzel

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: ~

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Kaus
(Address) Cottonwood, Idaho

15. Filed Mar. 30 1929 A. F. Orr per J. O.
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) – 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

No physician in attendance. Had not been sick in bed. Died suddenly, probably, some heart trouble.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) She had been dead about 10 minutes before I arrived.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. A. Woodcock M. D.
3-6 1929 (Address) Cottonwood, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cottonwood, Ida. | DATE OF BURIAL: 3-7-1929

20. UNDERTAKER: Tony Nau | ADDRESS: Cottonwood

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65336

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 4

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elmer Oliver Carpenter

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 1 | Months 11 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grangeville

PARENTS

10. NAME OF FATHER Donald T Carpenter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Manton Mich
12. MAIDEN NAME OF MOTHER Helen M Perkins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) P Wak

14. Informant Donald T. Carpenter
(Address)

15. Filed 3-1-, 1929 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21, 1929, to Jan 21, 1929
that I last saw him alive on Jan 21, 1929
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Lye Poisoning
Accidental
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Symptoms History
(Signed) John P Weber, M. D.
Jan 21, 1929 (Address) Grangeville.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grangeville Ida. | Date of Burial: 1-24-1929

20. Undertaker: E. S. Hunsack | Address: Grangeville

RECEIVED APR 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65337

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5

2. FULL NAME Mary Jane Eastman
(a) Residence. No. ..... Grangeville St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of W

6. DATE OF BIRTH (month, day and year) Nov 28 1842

7. AGE Years 86 Months 1 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hous W
(b) General nature of industry, business, or establishment in which employed (or employer) H W
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS
10. NAME OF FATHER Mathew Fountain Eastman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) V
12. MAIDEN NAME OF MOTHER Sarah Hicks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Pearl Campbell
(Address) Grangeville Idaho

15. Filed 3-1, 1929 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-1, 1929, to 1-14, 1929
that I last saw her alive on 1-12, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Influenza
..... (duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary) Senile condition
..... (duration) ..... yrs. 6 mos. ..... ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) J D Shinnick, M. D.
Feb 13, 1929 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville Ida
Date of Burial 1-16- 1929

20. Undertaker E S Hancock
Address Grangeville Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65338

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 6

PLACE OF DEATH
County of Idaho
City of Grangeville
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Elizabeth Pugh

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Grandville D. Pugh.

6. DATE OF BIRTH (month, day and year): July 28 - 1852

7. AGE: Years 76 | Months 6 | Days 4 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): ~~Great~~ Brookston Ind.

PARENTS

10. NAME OF FATHER: —
11. BIRTHPLACE OF FATHER (city or town) (State or Country): —
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): —

14. Informant: Robt. Pugh.
(Address) Grangeville Ida

15. Filed 3-1-, 1929 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~June~~ Feb. ~~30~~ 1 (Month) (Day) 1929

17. I HEREBY CERTIFY, That I attended deceased from June, 1925, to Jan 31, 1929
that I last saw h~~e~~r alive on Jan 31, 1929
and that death occurred, on the date stated above, at 1 p. m.
The CAUSE OF DEATH was as follows:
Chronic Interstitial Nephritis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Missing findings
(Signed) B. Chipman, M. D.
2-2-, 1929 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grangeville Ida — Date of Burial: 2-3- 1929

20. Undertaker: C.S. Hancock — Address: Grangeville

RECEIVED APR 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65339

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No.)
Local Registrar's No. 7

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isora Annie Harlan

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ashley R. Harlan

6. DATE OF BIRTH (month, day and year): Dec 3 - 1861

7. AGE: Years 67 | Months 1 | Days 28 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): -
(c) Name of employer: -

9. BIRTHPLACE (city or town) (State or country): Darlington Wis.

PARENTS

10. NAME OF FATHER: Ambrose S. Dunmer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Ray Harlan
(Address): Grangeville Ida.

15. Filed 3-1-, 1929 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 1 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1929, to June 31, 1929
that I last saw her alive on June 31, 1929
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of -
Was there an autopsy? no
What test confirmed diagnosis? Symptomatic
(Signed) B. Chipman, M. D.
2-4-, 1929 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grangeville Ida — Date of Burial: 2-4- 1929

20. Undertaker: Ed. Hancock — Address: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65340

Local Registrar's No. 8

PLACE OF DEATH

County of Idaho

City of Grangeville

Registration District No. 103

Primary Registration District No. 1001

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Callan

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 24 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Lucy Callan

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	2	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer & Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) F B

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Uniontown Pa

PARENTS

10. NAME OF FATHER Michal Callan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Catherine Mahuter

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Mrs Geo. Chase
(Address) Ferry Ida.

15. Filed 4-1-, 1929 B. Chipman
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 16- (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1928, to Feb 16, 1929 that I last saw h~~im~~ alive on Feb 16, 1929 and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Dilated Heart and Angina Pectoris

(duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Enlarged Heart

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Enlarged Heart

(Signed) B. Chipman, M. D.

3-29, 1929 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida.	3-21-1929

20. Undertaker C G. Hunerock — Address Grangeville Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65341

PLACE OF DEATH

County of Idaho

City of Joseph

Registration District No. 103

Primary Registration District No. 2181

Local Registrar's No. 9

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME C D Denron (Denron)

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) 1871

7. AGE Years 58 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ranch Hand

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Chas P. Miller
(Address) Grangeville Ida.

15. Filed 4-1-, 1929 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 7 (Day) - 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

No attending Physician

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) B. Chipman, M. D.

....., 19..... (Address) Local Registrar Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville Ida. Date of Burial 3-9- 1929

20. Undertaker C. A. Hancock. Address Grangeville Ida.

RECEIVED APR 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65342

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001

Local Registrar's No. 10

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Miss Jessie Pearson

(a) Residence. No. ..... Grangeville St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6. DATE OF BIRTH (month, day and year) May 1 1838

7. AGE	Years	Months	Days	If LESS than 1 day,
(40)	90	5	29	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) H K
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chautauqua County N.Y.

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Ray D Pearson
(Address) Grangeville Idaho

15. Filed 4-1-, 1929 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3- (Month) 18- (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-8-, 1929, to 2-18-, 1929
that I last saw h.. alive on 2-18-, 1929
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Influenza

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....

(Signed) J. D. Shumack, M. D.
March 20, 1929 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida.	2-20 1929
20. Undertaker C. C. Hancock	Address Grangeville Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 3 / 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65343

PLACE OF DEATH
County of Idaho
City of Grangeville
Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 11
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Le Colvin

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary R Colvin

6. DATE OF BIRTH (month, day and year) June 9 1853

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	9	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher & Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bert Kafer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER George Colvin
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Guy R. Colvin Sr.
(Address) Grangeville Ida.

15. Filed 4-1-, 1929 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20, 1929, to March 20, 1929
that I last saw him alive on March 20, 1929
and that death occurred, on the date stated above, at 4 45 a m.
The CAUSE OF DEATH* was as follows:
Dilatation of Heart
(duration) yrs. mos. 1/2 ds.
CONTRIBUTORY (Secondary) Acute Pancreatitis
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? no
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) C C Hancock M. D.
March 20, 1929 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida	3-22 1929

20. Undertaker C C Hancock
Address Grangeville Ida.

RECEIVED APR 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65344

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 12

(No. .....)
(If death occurred in a hospital or institution, give its name ~~instead~~ of street and number.)

2. FULL NAME Katie Albertad Altman

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ~~W~~ Y
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Jan~~ E H Altman

6. DATE OF BIRTH (month, day and year) 1896 Oct 24

7. AGE Years 32 Months 4 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Steam Boat S Crado

PARENTS
10. NAME OF FATHER Jopher Hitchen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Jane May
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant E H Altman
(Address) Grangeville Ida.

15. Filed 4-1-, 1929 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19, 1929, to March 21, 1929
that I last saw her alive on March 19, 1929
and that death occurred, on the date stated above, at 8:30 P m.
The CAUSE OF DEATH* was as follows:
Septic Sore Thread
Septic Endocarditis
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) John P Weber, M. D.
3-21, 1929 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville Ida. Date of Burial 3-25-1929

20. Undertaker C. A. Hancock Address Grangeville Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 3 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65345

PLACE OF DEATH
County of Idaho
City of Grangeville
Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 13
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nancy Jones-Henderson

(a) Residence. No. 418 State St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Jones

6. DATE OF BIRTH (month, day and year) 1857-4-5

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	11	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Glade Springs Va.

PARENTS

10. NAME OF FATHER William P. Crow
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER E. M. Kelly
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Va.

14. Informant Ethel E. Riggins
(Address) Grangeville Ida

15. Filed 4-1-, 1929 L. B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1924, to March 24, 1929
that I last saw h- alive on March 23, 1929
and that death occurred, on the date stated above, at 6 0 m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
&
Senility
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L. G. Weleg, M. D.
March 24 1929 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida	3-28-1929

20. Undertaker C. G. Hancock Address Grangeville Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65346

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14

2. FULL NAME Sadie Jean Brown

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 12, 1925

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
3	2	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grangeville, Idaho

PARENTS

10. NAME OF FATHER Herbert E. Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Weiser, Idaho
12. MAIDEN NAME OF MOTHER Louise De Haven
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Grangeville Idaho

14. Informant Herbert E. Brown
(Address) Grangeville Idaho

15. Filed 4-1-, 1929 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11, 1928, to 3-2, 1929
that I last saw her alive on 3-2, 1929
and that death occurred, on the date stated above, at 5 30 A m.
The CAUSE OF DEATH* was as follows:
Influenza & Follicular
Tonsillitis Inter Ear
Mastoidectomy & Abscess Brain
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of 2-28-29
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) John P Weber, M. D.
3-30, 1929 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane Wash. Date of Burial: 3-12-1929

20. Undertaker: C A Hancock Address: Grangeville Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65347

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15

2. FULL NAME Ernest O. Brown

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence F. Brown

6. DATE OF BIRTH (month, day and year): Sept. 30, 1868

7. AGE: 60 Years | Months: 5 | Days: 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mail Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): Stage
(c) Name of employer: Self

9. BIRTHPLACE (city or town) (State or country): The Dalles, Oregon

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Herbert E. Brown
(Address): Grangeville Idaho

15. Filed 4-1-, 1929 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 14, 1928, to 3-10, 1929
that I last saw him alive on 3-10, 1929
and that death occurred, on the date stated above, at 3 a.m.
The CAUSE OF DEATH* was as follows:

Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) J. P. Weber, M. D.
3-30, 1929 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane Wash | Date of Burial: 3-12-1929

20. Undertaker: C. G. Hundcock | Address: Grangeville Ida.

FORM V. S. No. [illegible] RECEIVED APR 3 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
File No. 65348
Registered No. 27

1. PLACE OF DEATH
County of Nez Perce
City of Melrose
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Norman Dee Holliday
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: July (Month) 27 (Day) 1928 (Year)

7. AGE: — Yrs. 7 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Melrose Idaho

10. NAME OF FATHER: Walter Dee Holliday

11. BIRTHPLACE OF FATHER (State or Country): Winchester Idaho

12. MAIDEN NAME OF MOTHER: Beulah J. Bacon

13. BIRTHPLACE OF MOTHER (State or Country): Melrose Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D. Holliday
(Address) Melrose

15. Filed 3-11 1929 E. E. Watts, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19— to — 19—
that I last saw him alive on 7-27 1929,
and that death occurred on the date stated above, at 8:20 a. M.
The CAUSE OF DEATH* was as follows:
Gastro Enteritis

(Duration) — Yrs. — mos. 7 ds.
Contributory (Secondary): Convulsions
(Duration) — yrs. — mos. 1 ds.

(Signed) E. E. Watts M. D.
3-11 1929 (Address) Gifford Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Melrose Ida — DATE OF BURIAL: 3-11 1929

20. UNDERTAKER: Geo Richardson ach — ADDRESS: Melrose

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 98

DO NOT WRITE IN THIS SPACE
State File No. 65349

PLACE OF DEATH
County of Jefferson.
City of Rigby.

Registration District No. 98
Primary Registration District No. 2176
(No.)

Local Registrar's No. 18

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Geraldine Thomas.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Babe.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb. 22, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Babe.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rigby, Idaho.

PARENTS

10 NAME OF FATHER Alex Thomas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Utah.

12 MAIDEN NAME OF MOTHER Marvella Harris.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho.

14 Informant Alex Thomas
(Address) Rigby, Idaho.

15 Filed 4-1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 23 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1929, to Feb. 23, 1929,
that I last saw h... alive on ..., 19...,
and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:
Prematurity, 6½ mos.
No known cause in mother

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [signature], M. D.
Nov 6, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Sugar City, Idaho. Date of Burial: 2/23/29 19

20. Undertaker [signature] Address: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65350

PLACE OF DEATH

County of Jefferson.

City of Rigby

CERTIFICATE OF DEATH

Registration District No. 98

Primary Registration District No. 2176

Local Registrar's No. 17

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Luna Caroline Jardine.

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F. M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced [redacted] (or) WIFE of Richard F. Jardine.

6 DATE OF BIRTH (month, day and year) Nov. 17, 1854

7 AGE: Years 74 | Months 3 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salt Lake City, Utah.

PARENTS

10 NAME OF FATHER Edmund Ellsworth.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Elizabeth Young.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Joe A Jardine

(Address) Buhl Idaho R1

15 Filed 4-1, 1929 C H Savin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February (Month) 27th (Day), 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h..... alive on ....., 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chr Valvular Heart Disease

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. R. West, M. D.

Mar. 1, 1929 (Address) Rigby Idaho County Physician

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Lewisville, Idaho. Date of Burial: 3/2/29 19

20. Undertaker: A B Eckersell Address: Rigby.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65351

PLACE OF DEATH
County of Jefferson.
City of Lorenzo.

Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No. 16

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME La Vera (Cook) Connell.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Married.

5a. If married, widowed, or divorced
(or) WIFE of Edward H. Connell.

6. DATE OF BIRTH (month, day and year) Jan. 8 1890

7. AGE	Years	Months	Days	If LESS than 1 day,
	39	2	11	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Isacc Cook.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Martha Holden.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant .....
(Address) Rigby, Idaho.

15. Filed 4-1, 1929 C. A. Larsen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 19, 1929, to ....., 19....
that I last saw her alive on Mar. 19, 1929
and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:
Chr. Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) W. R. West, M. D.
Mar 22 1929 (Address) Rigby, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho.	3/22/29 19

20. Undertaker C. A. Larsen Address Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65352

PLACE OF DEATH

County of Jefferson

City of Rigby.

CERTIFICATE OF DEATH

Registration District No. 98

Primary Registration District No. 2176

(No. .....)

Local Registrar's No. 15

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Henry Anthony Schweitzer.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or ~~XXXXXX~~ Persis Schweitzer.

6 DATE OF BIRTH (month, day and year) Nov. 7, 1867

7 AGE: Years 61 | Months 3 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Retired.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio.

PARENTS

10 NAME OF FATHER: Anthony Schweitzer.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Wagner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Belgium.

14 Informant: Mrs H A Schweitzer

(Address) Rigby, Idaho.

15 Filed 4-1, 1929 O H Tarin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: February (Month) 14 (Day) 1929 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st 1922, 19—, to Feb 14, 1929, that I last saw him alive on Feb 13th, 1929, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Degeneration

(duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Not Known

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical examinations

(Signed) F. A. Anderson, M. D.

....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rigby, Idaho.

Date of Burial: 2/18/29 19

20. Undertaker: [illegible] Rigby.

Address

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65353

PLACE OF DEATH
County of Jefferson
City of Lewisville.

Registration District No. 98
Primary Registration District No. 2176
(No.)

Local Registrar's No. 14

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Lewis Vallier.

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or WIFE of) Mary Vallier.

6 DATE OF BIRTH (month, day and year) April 25, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	9	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10 NAME OF FATHER Vallier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Mrs Jane Walker
(Address) Lewisville, Idaho.

15 Filed 4-1, 19 29 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
February, 18 1929
(Month) (Day) (Year) 19

17 I HEREBY CERTIFY, That I attended deceased from
On Feb 0K, 1929, to [illegible], 19
that I last saw him alive on Feb 0K, 1929,
and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:
Paralytic Stroke

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) H. A. Anderson, M. D.
Feb 18th, 1929 (Address) Rigby - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Lewisville, Idaho.	2/20/29 19

20. Undertaker [signature] Address Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65354

PLACE OF DEATH
County of Jefferson
City of Rigby.

CERTIFICATE OF DEATH
Registration District No. 98
Primary Registration District No. 2176
(No.)
Local Registrar's No. 13

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Eva Opal George.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F. M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas C. George Jr.

6 DATE OF BIRTH (month, day and year) May 21, 1905

7 AGE: Years 23 | Months 9 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rigby, Idaho.

PARENTS

10 NAME OF FATHER: Arthur E. Cordon.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Utah.

12 MAIDEN NAME OF MOTHER: Mary Jane Whitaker.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Utah.

14 Informant: Thomas C. George Jr.
(Address) Rigby, Idaho.

15 Filed 3-1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 24 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Feb 24, 1929, that I last saw her alive on Feb 24, 1929, and that death occurred, on the date stated above, at 7:30a m.

The CAUSE OF DEATH* was as follows:
Valvular Heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

2-25, 1929 (Address) Rigby

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho.	2/27/29

20. Undertaker [signature] | Address: Rigby.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65355

PLACE OF DEATH
County of Jefferson.
City of Rigby.

CERTIFICATE OF DEATH
Registration District No. 98
Primary Registration District No. 2176
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 12

2. FULL NAME Birlie Luella Daley.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F. M.
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 28, 1882

7 AGE: Years 46 | Months 6 | Days 29 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10 NAME OF FATHER Cyrus H. Daley.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.
12 MAIDEN NAME OF MOTHER Olive Roylance.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah

14 Informant Mrs J. W. Milner
(Address) Rigby, Idaho . R. #1

15 Filed 4-1, 1929 C H Tarin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb (Month) 26th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1929, to Feb 25, 1929, that I last saw her alive on Feb 25th, 1929, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:
Progressive Cerebrospinal Paralysis
(duration) 20 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical examination only
(Signed) H. A. Anderson, M. D.
....., 19..... (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Springville, Utah
Date of Burial: 2/28/29 19

20. Undertaker: A B Edwards
Address: Rigby.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—37 M. 1-19 RECEIVED APR 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jerome

City of Hazelton

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23

Primary Registration District No. 2017

(No. ..... St.)

File No. 65356

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Idella Burgess

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FM

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widowed (Write the word.)

6. DATE OF BIRTH: May (Month) 27 (Day) 1865 (Year)

7. AGE: 64 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Ruben Rearick

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Paulina Maxwell

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Goldie I. Bryant

(Address) Hazelton Idaho

15. Filed Apr 1 1929 S Hopper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1929, to Mar 9 1929 that I last saw her alive on Mar 9 1929, and that death occurred on the date stated above, at 7:55 P.M.

The CAUSE OF DEATH* was as follows:

Uterine Cancer

..... (Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Simeon Hopper M. D.

..... 19 ..... (Address) Hazelton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Hazelton Idaho

Former or usual residence Hazelton Ida

19. PLACE OF BURIAL OR REMOVAL: Hazelton Ida

DATE OF BURIAL: 3-12 1929

20. UNDERTAKER: none

ADDRESS: —

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65357

PLACE OF DEATH

County of Kootenai
City of Post Falls

Registration District No. 30
Primary Registration District No. 10 57

Local Registrar's No. 48

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Iowa Silvia Chase

(a) Residence. No. Post Falls St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of C M Chase

6. DATE OF BIRTH (month, day and year) Mch 1, 1890

7. AGE	Years	Months	Days	If LESS than 1 day,
	39	0	10	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Emerald
(State or country) Iowa

PARENTS

10. NAME OF FATHER Irvin A Libby

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Ella Gubbe

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Iowa

14. Informant C. M. Chase
(Address) Post Falls Ida

15. Filed 3/13, 1929 DD. Drennan Registrar
N.B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1929, to March 11, 1929
that I last saw h[illegible] alive on March 10 1929
and that death occurred, on the date stated above, at 6 [illegible] m.

The CAUSE OF DEATH* was as follows:

Flue with heart Failure (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) B E McCoy, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Post Falls Cemetery	3/13 1929

20. Undertaker	Address
R. B. Mooney	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65358

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1051
Local Registrar's No. 426
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth Agnes Swanson

(a) Residence. No. 814 — 5th St.
(Usual place of abode)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Feb 3, 1927

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	1	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho

PARENTS

10. NAME OF FATHER P. J. Swanson
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) So Dak
12. MAIDEN NAME OF MOTHER Agnes Mevig
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Norway

14. Informant Rev. P. J. Swanson
(Address) Coeur d'Alene Ida

15. Filed 3/7, 1929 D D Drennan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4, 1929, to March 6, 1929
that I last saw her alive on March 6, 1929
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia, right

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Do not know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Harold T. Anderson, M. D.
March 6, 1929 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	March 8 1929
20. Undertaker	Address
R B Mooney	CdA

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AP

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65359

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1051
Local Registrar's No. 47
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Hansen
(a) Residence. No. 966 - 7th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widowed

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Paul Hansen

6. DATE OF BIRTH (month, day and year) -11-12

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER Joseph Phillips
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Martha Phillips - Phelps
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Pauline Martin
(Address) 309 Cda ave Coeur d'alene

15. Filed 3/12, 1929 D D Drennon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to March, 1929, that I last saw her alive on March 7, 1929, and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
..... (duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Influenza
..... (duration) ..... yrs. ..... mos. 14 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) John D Wood, M.D.
March 11, 1929 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boulder Colo	3-16 1929
20. Undertaker	Address
Cossedy Funeral Home	Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65360

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1051
Local Registrar's No. 57

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frederica Schneider

(a) Residence. No. 1406 - N. 8th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widowed

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of John Schneider

6. DATE OF BIRTH (month, day and year) 1851 - 11 -

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER —— French
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs W H Smith
(Address) 1406 N 8th St

15. Filed Apr 3, 1929 N. J. Sturgeon mar. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28, 1929, to Mar. 29, 1929
that I last saw h alive on March 29, 1929
and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of pancreas and common bile duct.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? Autopsy.

(Signed) John A Wood, M. D.
March 31 1929 (Address) Coeur d'Alene Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Lawn Cem. CdAlene	3-31 1929
20. Undertaker	Address
Cassedy Funeral Home	CdAlene

RECEIVED APR 6

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65361

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Amelia L. Kauffman

(a) Residence. No. 1032 Fourth St. Opera Michigan
(Usual place of abode) (If nonresident give city of town and State)
Length of residence in city or town where death occurred. yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Geo F Kauffman

6. DATE OF BIRTH (month, day and year) Dec 27, 1865

7. AGE	Years	Months	Days	If LESS than 1 day,
	63	2	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Opera
(State or country) Michigan

PARENTS

10. NAME OF FATHER John King
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Mary Ann Ellery
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Geo F Kauffman
(Address) Coeur d'Alene Ida

15. Filed 3/31, 1929. H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13, 1929 to March 19, 1929
that I last saw her alive on March 12, 1929
and that death occurred, on the date stated above, at 6:20 P m.

The CAUSE OF DEATH* was as follows:
Chr. Myocarditis
Cerebral hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Terminal pneumonia
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Harold J. Sturges, M. D.
3-21-, 1929 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Opera Mich.	3/22 1929

20. Undertaker	Address
R B Mooney	Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65362

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1051

Local Registrar's No. 56

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank E. Stickney

(a) Residence. No. 1005 - Elm St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Eliza Stickney

6. DATE OF BIRTH (month, day and year) 1851-12-28

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	2	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Erie Co North Collins N.Y.

PARENTS

10. NAME OF FATHER Truman L. Stickney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.
12. MAIDEN NAME OF MOTHER Lydia Heath
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant Eliza M. Stickney
(Address) 1005 - Elm St. C'Alene

15. Filed 4-3, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1929 to March 26, 1929
that I last saw him alive on March 26, 1929
and that death occurred, on the date stated above, at 12.03 a m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia.

(duration) ... yrs. ... mos. 2 ds.
CONTRIBUTORY (Secondary) Influenza.
(duration) ... yrs. 1 mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John D. Lyon M. D.
March 28, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C'Alene	3-30 1929
20. Undertaker	Address
Cassedy Funeral Dir.	C'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65363

Registration District No. 30

Primary Registration District No. 1051

Local Registrar's No. 49

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene (No. ....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Hanson

(a) Residence. No. 206 Garden St. 1

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Nellie Hanson

6. DATE OF BIRTH (month, day and year) 1866-12-31

7. AGE	Years	Months	Days	If LESS than 1 day,
	62	3	0	....hrs. or ....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Hanson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Oscar F. Hanson

(Address) Coeur d'alene Idaho

15. Filed Apr 3 1929 H. J. Sturges mch Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1926 to Mch 31 1929

that I last saw h~~e~~r alive on Mch 20 1929

and that death occurred, on the date stated above, at 8 30 Am.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

(duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of Jan. 1929

Was there an autopsy? No What test confirmed diagnosis? Exploratory Operation

(Signed) J C Burns, M. D.

April 2, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CDAlene	4-2 1929
20. Undertaker Cassedy Funeral Home	Address CDAlen

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, FRACTIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65364

PLACE OF DEATH
County of Kootenai Registration District No. 30
City of Coeur d'Alene Primary Registration District No. 1057
Local Registrar's No. 52
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Melvin Sandusa
(a) Residence. No. 841 N Fourth St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) May 21 - 1921

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	19	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho

PARENTS

10. NAME OF FATHER Fred Sandusa
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Gertrude Swan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn

14. Informant Fred Sandusa
(Address) Coeur d'Alene Ida.

15. Filed 4-3, 1929 W. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1928, to Mar 24, 1929
that I last saw him alive on Mar 22, 1929
and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular heart lesion
(duration) yrs. 3 mos. 3 ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. 1 mos. 15 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? X Ray
(Signed) F. E. H. Teed M. D.
3-26, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	3/26 1929
20. Undertaker	Address
R B Mooney	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65365

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No.
Primary Registration District No.
Local Registrar's No. 54
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John W. Stromberg
(a) Residence No. 1030 - 2nd St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Emma C. Stromberg

6. DATE OF BIRTH (month, day and year) 3-11-

7. AGE	Years	Months	Days	If LESS than 1 day,
	83		9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Fruit-grower
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER John Frederic Stromberg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Dorothea
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs E. H. Gay
(Address)

15. Filed 4-3, 1929 H. J. Sturges Asst. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1928, to Mar 20, 1929
that I last saw h~~e~~r alive on Mar 20, 1929
and that death occurred, on the date stated above, at 8 35 P m.
The CAUSE OF DEATH* was as follows:
Cancer of Bladder.
(duration) 1 yrs. 6 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J C Davis, M. D.
Mar 23, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C'dAlene	3-28 1929
20. Undertaker Cassady Funeral Home	Address C'dAlene

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65366

PLACE OF DEATH
County of Kootenai
City of Hayden Lake
Registration District No. 30
Primary Registration District No. 1051
Local Registrar's No. 55
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Annie Katherine Kifer

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Andrew J. Kifer

6. DATE OF BIRTH (month, day and year) 1889-8-27

7. AGE	Years	Months	Days	If LESS than 1 day,
	39	6	26	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Rockwood Minn
(State or country)

PARENTS

10. NAME OF FATHER Chas Meyer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant A. J. Kifer
(Address) Hayden Lake.

15. Filed 4-3, 1929 H. J. Sturges (MK) Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27, 1929, to March 25, 1929
that I last saw her alive on March 23, 1929
and that death occurred, on the date stated above, at 11:45 P. m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Hayden Lake, Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Exam.
(Signed) Harold J. Sturges, M. D.
March 27, 1929 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C'D'Alene	3-27 1929
20. Undertaker	Address
Cassedy Funeral Dir.	C'D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 19..

PLACE OF DEATH

County of Kootenai

City of Post Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65367

Registration District No. 30

Primary Registration District No. 1051

Local Registrar's No. 47

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Virgil Watson

(a) Residence. No. Post Falls St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Watson

6. DATE OF BIRTH (month, day and year) Aug 25, 1877

7. AGE Years 51 Months 7 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Section Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer G Northern R.R.

9. BIRTHPLACE (city or town) (State or country) N Carolina

PARENTS

10. NAME OF FATHER C Watson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. C.

12. MAIDEN NAME OF MOTHER Caroline Jones

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. C.

14. Informant Mrs Mollie Watson

(Address) Post Falls Ida.

15. Filed 3/31, 1929 H. J. Sturges (MK) Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 25 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows: Gun Shot Wound in Head. (Suicide)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) R B Mooney Brown, M. D.

3/25, 1929 (Address) Point Blue

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Oaksdale Wm

Date of Burial 3/28 1929

20. Undertaker R B Mooney

Address Post Falls Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65368

Registration District No. 64
Primary Registration District No. 2144
Local Registrar's No. ____
(No. ____)

PLACE OF DEATH
County of Latah
City of Troy

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dona Jean Arnol

(a) Residence. No. ____ St. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced. (write the word)
Fem	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 11—1926

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	4	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Moscow Idaho

PARENTS

10. NAME OF FATHER Leo Delance Arnol
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Troy Ida
12. MAIDEN NAME OF MOTHER Grace May Henderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Leo Arnol
(Address) Troy Ida

15. Filed March 31, 1929 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 1st. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1. 1929 to March 1. 1929
that I last saw her alive on Jan. 25 1929
and that death occurred, on the date stated above, at 8 30 P. m.
The CAUSE OF DEATH* was as follows:
acute Myocarditis
Heart collapse
(duration) ____ yrs. ____ mos. 1. ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? ____
(Signed) Leo A. Meyer, M. D.
March 7, 1929 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow Ida	March 3 1929
20. Undertaker	Address
John J. Pickerd	Troy Ida

RECEIVED APR 10 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65369

PLACE OF DEATH
County of Latah
~~City of~~ Park, Ida.

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Andrew N. Sundby

(a) Residence: ~~No.~~ Park, Idaho ~~St~~
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 25 - 1856

7. AGE Years	Months	Days	If LESS than 1 day,
72	6	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10. NAME OF FATHER: Nels K. Sundby
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Sophie Paulson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Mrs. R. C. Dahl
(Address): Park Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1928, to March 18, 1929
that I last saw him alive on Sept. 1, 1928
and that death occurred, on the date stated above, at 4:00 p.m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Chas. A. Meyer, M.D.
March 18, 1929 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Park Ida	Mar 21 1929
20. Undertaker	Address
John J. Pickerd sold Casket	Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 10 192

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65370

PLACE OF DEATH
County of Latah
City of Deary

Registration District No. 64
Primary Registration District No. 2144
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Baker

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	3	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ky
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ky

14. Informant: Mrs Baker
(Address): Deary Ida

15. Filed March 31, 1929 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to March 23, 1929, that I last saw h-m alive on March 16, 1929, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Chas A Meyer M. D.
Mar 23, 1929. (Address) Troy, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Little Bear Ridge	Mar 25 - 1929

20. Undertaker	Address
John J Pickerd	Troy Ida

I sold casket -

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65371

Local Registrar's No. No

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME LENA KESEL

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of CORNAD KESEL

6 DATE OF BIRTH (month, day and year) Dec. 18-1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fountnell, Iowa.

PARENTS
10 NAME OF FATHER WERY
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER " "
13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Fred Kesel
(Address) Wenatchee, Wash.

15 Filed Mch 22 1929 W. J. Hawthorne Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 22 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1929, to March 22, 1929, that I last saw h[illegible] alive on March 22, 1929, and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows: Paralysis of whole left side and old age infirmity Also paralysis of throat last

(duration) yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. W. Leitch M. D.
3/25 1929 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Moscow Ida. — Date of Burial: Mar. 26 1929
20. Undertaker: H. R. Short — Address: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65372

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Latah Registration District No. 61

City of Moscow Primary Registration District No. 1011

(No. .....)

Local Registrar's No. 17

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Frank Alva David

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ella M. David

6 DATE OF BIRTH (month, day and year) Feb. 18, 1855

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74		19	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Montfort, Wis.

PARENTS

10 NAME OF FATHER Isaac David

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vir.

12 MAIDEN NAME OF MOTHER Ruark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Homer David
(Address) Moscow, Idaho

15 Filed Mch 7, 1929 W. H. Leavitthers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 7, 1929
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1926, to March 7, 1929, that I last saw h. alive on March 7, 1929, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Apoplexy.

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. H. Leavitthers, M. D.

3/8, 19 29 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow	3/9/29 19
20. Undertaker F. R. Hunt	Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 10

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 65373

PLACE OF DEATH

County of Latah

City of Moscow

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

(No. U. of I. Infirmary)

Local Registrar's No. 13

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. **FULL NAME** Irene Delight Thompson

(a) Residence. No. - St. Spokane, Wash.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) March 31, 1908

7 AGE: Years 20 | Months 11 | Days 5 | If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer): University of Idaho

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Spokane, Wash.

PARENTS

10 NAME OF FATHER: Louis Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Minn.

12 MAIDEN NAME OF MOTHER: Lottie I. Schull

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wis.

14 Informant: D.M. Thompson

(Address) Post Falls, Idaho

15 Filed Mch 5, 1929 W.H. Carithers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Mar. (Month) 5 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1929, to Mar. 5, 1929, that I last saw her alive on Mar. 5, 1929 and that death occurred, on the date stated above, at 10:40 a.m.

The CAUSE OF DEATH* was as follows:

Septicemia Streptococcus

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Tonsilitis acute

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Harry Einhouse, M. D.

Mar. 5, 1929 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Spokane, Wash.

Date of Burial: 3/7/29 19

20. Undertaker: F. R. Short

Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65374

PLACE OF DEATH

County of Latah
City of Moscow

Registration District No. 101
Primary Registration District No. 1011
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 14

2. **FULL NAME** Bonnie Margille Fletcher

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) March 8 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Moscow, Idaho

PARENTS

10 NAME OF FATHER: Elliott Fletcher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maine

12 MAIDEN NAME OF MOTHER: Eunice Fletcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Idaho

14 Informant: Elliott Fletcher
(Address): Moscow, Idaho

15 Filed March 10, 1929 W. H. Gaithers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 10, (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 8th, 1929, to Mar 10, 1929
that I last saw her alive on Mar 8th, 1929,
and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:
Cardiac Disease
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H. H. Magee, M. D.
3/10 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow	3/10/29 19

20. Undertaker: L. R. Short — Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65375

PLACE OF DEATH

County of Latah

City of Moscow

CERTIFICATE OF DEATH

Registration District No. 101

Primary Registration District No. 1011

(No. Gritman Hospital)

(If death occurred in a hospital or institution, give it name instead instead of street and number.)

Local Registrar's No. 15

2. **FULL NAME** Martin Alonzo Pinson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan. 1, 1912

7 AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
17	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work High School Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Clarkston Wash.

PARENTS

10 NAME OF FATHER Wm. D. Pinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Vir.

12 MAIDEN NAME OF MOTHER Bessie A. Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Wm. D. Pinson

(Address) Moscow, Idaho

15 Filed Mch 28 1929 W. H. Carithers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 28, 1929 (Month) (Day) 19__ (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1929, to March 28, 1929, that I last saw him alive on March 28, 1929, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:
Nonepidemic cerebrospinal Meningitis.
Staphylococcus
(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Chlorosis mexica.
(duration) ___ yrs. ___ mos. 7 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Date of Paracentesis of Year.

Was there an autopsy? no

What test confirmed diagnosis? Clinical only.

(Signed) C. O. Armstrong, M. D.

Mar. 28 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow	3/31 1929

20. Undertaker	Address
H. R. Short	Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 1 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65376

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Mary Nadawit
(a) Residence. No. Salmon St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Indian
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joe Nadawit
6. DATE OF BIRTH (month, day and year)
7. AGE Years 80 Months Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant Mrs Frank Durand.
(Address) Salmon Ida.
15. Filed 3/6, 1929 Cho Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 11th 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 7 a — m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) William C Doebler Coroner D
3/11, 1929 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salmon Cemetery
Date of Burial 3-12" 1929
20. Undertaker Wm. Doebler
Address Salmon

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 1 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65377

PLACE OF DEATH
County of Lemhi
City of Gilmore

Registration District No. 4
Primary Registration District No. 2116
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Albert Mc. Clain

(a) Residence. No. Gilmore Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Not known

7. AGE: Years: about 65 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Quartz Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Penn.

PARENTS

10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: William C Doebler
(Address): Salmon Idaho

15. Filed 3/5 19 29 Clint Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 23rd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows: Dynamite explosion, with Suicida intent, self inflicted
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Wm C Doebler Coroner M.D.
3/1st, 19 29 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pittsburg Penn
Date of Burial: 19

20. Undertaker: Wm C Doebler
Address: Salmon Ida

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65379

PLACE OF DEATH
County of Lincoln
City of Richfield
Registration District No. 1619
Primary Registration District No. 216
(No. 4 Miles North of Richfield)
Local Registrar's No. 7
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruland J Giles

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 5 1928

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	10	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Richfield Ida

PARENTS
10 NAME OF FATHER Joseph F Giles
11 BIRTHPLACE OF FATHER (city or town) (State or country) Heber City Utah
12 MAIDEN NAME OF MOTHER Mary Ellen Sweat
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Heber City Utah

14 Informant Ernest R Giles
(Address) .....

15 Filed Apr 5, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 4 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1929, to April 4, 1929
that I last saw h[illegible] alive on April 4, 1929
and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:
Double Lobar Pneumonia
(duration) ... yrs. ... mos. 7 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical Exam
(Signed) T. E. Barrett, M. D.
4/5, 1929 (Address) Shoshone

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Richfield Ida — Date of Burial: Apr 6 1929
20. Undertaker: C E Hickok — Address: Shoshone Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 65380

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Lincoln

City of Richfield

Registration District No. 10

Primary Registration District No. 2016

(No. .....)

Local Registrar's No. 6

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Hope Elizabeth Blakesley

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept 6 1916

7 AGE: Years 12 | Months 6 | Days 16 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Filer Idaho

PARENTS

10 NAME OF FATHER Earl R Blakesley

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York State

12 MAIDEN NAME OF MOTHER Ruby Conner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kansas

14 Informant Earl R Blakesley

(Address) Richfield

15 Filed Mch 23, 1929 J L Sussex Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar (Month) 22 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 22, 1929, to Mar 22, 1929, that I last saw her alive on Mar 22, 1929, and that death occurred, on the date stated above, at 9.45 A.M.

The CAUSE OF DEATH* was as follows: Cerebro-Spinal Fever

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Phy Exam

(Signed) F. E. Burgett, M. D.

3/23, 1929 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Richfield Ida

Date of Burial: Mar 22 1929

20. Undertaker: C E Hickok

Address: Shoshone Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 16

DO NOT WRITE IN THIS SPACE

State File No. 65381

Local Registrar's No. 6

PLACE OF DEATH

County of Lincoln Registration District No.

City of Shoshone Primary Registration District No. 1016

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mary M. Lewis

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sam Lewis

6 DATE OF BIRTH (month, day and year) Aug 28 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rochester N Y

PARENTS

10 NAME OF FATHER Nicholas Dries

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sam Lewis

(Address)

15 Filed Mch 18 1929 H. Sauer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 17 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 14, 1929, to Mar 14, 1929, that I last saw her alive on Mar 14, 1929, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin Exam.

(Signed) F. E. Barrett, M. D.

Mar 18, 1929 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Shoshone Idaho	Mar 19 1929
20. Undertaker	Address
C E Hickok	Shoshone Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65382

PLACE OF DEATH
County of Madison
City of Rexburg
Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 21
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Brown

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	0	0	hrs. or 15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rexburg, Idaho

PARENTS

10. NAME OF FATHER David Allen Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Ruby Ricks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Logan Utah

14. Informant D. A. Brown
(Address) Rexburg Idaho

15. Filed 3/10, 1929 J. Reyong Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-10, 1929, to 3-10, 1929
that I last saw h[illegible] alive on 3-10, 1929
and that death occurred, on the date stated above, at 11:30 P. m.
The CAUSE OF DEATH* was as follows:
Premature birth
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) M Rutherford M. D.
3-10, 1929 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg	3-11-29
20. Undertaker	Address
None	

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65383

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22

2. FULL NAME Jimmie Hirai

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Japanese
5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Oct. 8/1927

7. AGE: Years 1, Months 5, Days 7. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10. NAME OF FATHER: Seigo Hirai
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Japan
12. MAIDEN NAME OF MOTHER: Yasketo Shiomi
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Japan

14. Informant: T Joe
(Address) Rexburg Idaho

15. Filed 3/15, 1929 J Rejoung Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1928, to Feb 21, 1929
that I last saw him alive on Feb 21, 1929
and that death occurred, on the date stated above, at 10:30 P m.
The CAUSE OF DEATH* was as follows:
Convulsion.
..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary): Nephritis
..... (duration) ..... yrs. ..... ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? [illegible] tests & symptoms
(Signed) Louis I Rich, M. D.
3-15, 1929 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rexburg
Date of Burial: 3/16 1929

20. Undertaker: A B Eckersell
Address: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65384

PLACE OF DEATH
County of Madison
City of Sugar City

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

2. FULL NAME Mrs Hermeh Agnes Bird

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female		Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60	7	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Meadow Utah Cooke County

PARENTS

10. NAME OF FATHER Johnathon Willey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Gardner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Ray Park
(Address) Sugar city

15. Filed 3/25, 1929 J Rigsby Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24, 1929, to March 24, 1929
that I last saw her alive on March 24, 1929
and that death occurred, on the date stated above, at 4:000 m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis.
Arterio sclerosis (Senile)
Senile Dementia.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) H B Rigsby, M. D.
March 26, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19

20. Undertaker	Address
Elvin Green	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65385

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bonneville
City of Idaho Falls.

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 24

2. FULL NAME Sarah Allen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.
4 COLOR OR RACE: White.
5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Robert P. Allen.

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 48 | Months 5 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ogden. Utah

PARENTS
10 NAME OF FATHER: Ephraim J. Furness.
11 BIRTHPLACE OF FATHER (city or town) (State or country): Burnley England.
12 MAIDEN NAME OF MOTHER: Alzada R. Bird
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Provo. Utah

14 Informant: Alzada. R Bird Furness.
(Address) Teton City Idaho

15 Filed 3/25, 1929 J. V. Lyonnog Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 26 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 16, 1929, to Mar 26, 1929, that I last saw her alive on Mar 26, 1929, and that death occurred, on the date stated above, at 3:56 m.

The CAUSE OF DEATH* was as follows:
Acute & Chronic Myocarditis
(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary): Toxic Goiter
(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Laboratory
(Signed) J. Ray Hatch, M. D.
Mar 26, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Teton, Idaho
Date of Burial: 19

20. Undertaker: Alvin Keller
Address: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65386

PLACE OF DEATH
County of Madison
City of Archer

Registration District No. 100
Primary Registration District No. 2178
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 25

2. **FULL NAME** Carl Ashbacher

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Geneva Ashbacher

6. DATE OF BIRTH (month, day and year) June 2, 1895

7. AGE	Years	Months	Days	If LESS than 1 day,
	33	9	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9. BIRTHPLACE (city or town) Rexburg Idaho
(State or country)

PARENTS

10. NAME OF FATHER Jacob Ashbacher
11. BIRTHPLACE OF FATHER (city or town) Switzerland
(State or Country)
12. MAIDEN NAME OF MOTHER Eliza Gegger
13. BIRTHPLACE OF MOTHER (city or town) Switzerland
(State or Country)

14. Informant Mrs. Geneva Ashbacher
(Address) Archer Idaho

15. Filed 3/27, 1929 Wyoming Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 27. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19-, 1922, to Jan, 1929
that I last saw him alive on January, 1929
and that death occurred, on the date stated above, at 4 am m.
The CAUSE OF DEATH* was as follows:
Acute dilatation of heart
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? symptoms
(Signed) Lorin B Rich, M. D.
3-28, 1929 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Archer Idaho.	19
20. Undertaker	Address
C D Eckersell	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65387

PLACE OF DEATH

County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

2. FULL NAME Charles R. Cook

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Hazel Philips Cook

6. DATE OF BIRTH (month, day and year) Nov. 15, 1884

7. AGE 44 Years | Months 4 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Rexburg, Idaho

PARENTS

10. NAME OF FATHER James M. Cook
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Emily Jane Radcliffe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Chas R Cook
(Address) Rexburg

15. Filed 3/28, 1929 J. Cyrring Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1924 to Mar 28, 1929
that I last saw him alive on Mar. 27, 1929
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease
..... (duration) 5 yrs. ..... mos. + ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) J. Butterland, M. D.
3-29, 1929 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rexburg Cemetery | Date of Burial: 3/31 1929

20. Undertaker: A B Eckersdell | Address: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65388

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 27

PLACE OF DEATH
County of Madison
City of Thornton
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Hunsaker

(a) Residence. No. P.O. Thornton State Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 3 1863.

7. AGE: Years 65 | Months 11 | Days 3. | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark.

PARENTS:
10. NAME OF FATHER Andrus Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark.

14. Informant Miss Rose Hunsaker
(Address) Reno Nevada.

15. Filed 4/10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw her alive on , 19
and that death occurred, on the date stated above, at 9 12 A. m.

The CAUSE OF DEATH* was as follows:
Cancer of the Uterus involving the intestinal tract.
(duration) yrs. 13 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no

(Signed) [signature] M. D.
4-10, 1929 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lyman Idaho	4/9 1929.

20. Undertaker W. F. McHan Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65389

PLACE OF DEATH
County of Madison
City of Archer

Registration District No. 100
Primary Registration District No. 2178
(No.)
Local Registrar's No. 28

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ada Erickson.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Child.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 29, 1921

7. AGE	Years	Months	Days	If LESS than 1 day,
	7	3	9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Archer, Idaho.

PARENTS

10. NAME OF FATHER Herman Erickson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Gladys Edna Blackburn.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Herman Erickson
(Address) Thornton R. #1

15. Filed 4/10, 1929 J Rigsmy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 7 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, ~~That I attended deceased from~~ , 19 , ~~to~~ , 19 ~~that I last saw h alive on~~ , 19
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:

Accidently electrocuted

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H. Schwendiman, M. D. Coroner
April 8th, 1929 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Archer, Idaho.	4/9/29 19

20. Undertaker A Beckstead Address Rigby.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65390

Local Registrar's No. 29

PLACE OF DEATH
County of Madison
City of Sugar City
Registration District No. 100
Primary Registration District No. 2178
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Baby Rigby

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant.

6 DATE OF BIRTH (month, day and year) April 8, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or 45 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sugar City.

PARENTS
10 NAME OF FATHER David Merritt Rigby
11 BIRTHPLACE OF FATHER (city or town) (State or country) Sugar City Idaho.
12 MAIDEN NAME OF MOTHER Lulu Stockum
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rigby Idaho.

14 Informant David Merritt Rigby
(Address) Sugar City Idaho

15 Filed 4/10, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 8 (Month) (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to April 8, 1929, that I last saw h___ alive on April 8, 1929, and that death occurred, on the date stated above, at 5 Y.S. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Difficult labor. (Asphyxia)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A B Eckersell, M. D.
April 9, 1929 (Address) Rigburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Rigburg Cemetary	4/9 1929

20. Undertaker A B Eckersell Address Rigburg

RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65391

PLACE OF DEATH

County of Madison

City of Rexburg

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 12

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anthony Bates

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Jesse L. Bates

6. DATE OF BIRTH (month, day and year) Sept 29 1867

7. AGE: 61 Years, Months 4, Days 23. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer: Self.

9. BIRTHPLACE (city or town) (State or country): Wanship Utah

PARENTS

10. NAME OF FATHER: John Bates

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant Mrs. Jesse L. Bates
(Address) Sugar City Idaho

15. Filed 2/23, 1927 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct., 1928, to Feb. 22, 1929

that I last saw him alive on Feb. 22, 1929

and that death occurred, on the date stated above, at 6:00 a. m.

The CAUSE OF DEATH* was as follows:

Pancreatitis (Topening)
Chronic Cholocystitis
Chronic Appendicitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb. 14, 1929

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. B. Rigby, M. D.

Feb. 23, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salt Lake City, Utah — Date of Burial: 2/26 1929

20. Undertaker: A B Eckersell — Address: Rexburg

Salt Lake City, Cemetery

RECEIVED MAR 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65392

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

2. FULL NAME Francis M. Hiner

(a) Residence. No. St. (Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~

6. DATE OF BIRTH (month, day and year) May 10, 1869

7. AGE Years 59 Months 9 Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Des Moines Iowa

PARENTS
10. NAME OF FATHER George W. Hiner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana U.S.A.
12. MAIDEN NAME OF MOTHER Matilda Hughes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa U.S.A.

14. Informant Mrs F. M. Hiner
(Address) Rexburg Idaho.

15. Filed 2/16, 19 Wyoming Registrar

MEDICAL CERTIFICATE OF DEATH 746

16. DATE OF DEATH Feb (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12, 1929 to Feb 12, 1929
that I last saw him alive on Feb 12 - 1929
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Embolism - Cardiac
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Arterio-sclerosis
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? symptoms
(Signed) Louis F. Rich, M. D.
2-14, 1929 (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sugar City. Date of Burial 19

20. Undertaker A B Eckersell Address Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

In reference to the death certificate o.:

FRANCIS M. KINER who died February 12, 1929.

Information DESIRED in order to complete certificate:

1. Will you kindly give us his place of birth.

PLEASE ANSWER BELOW:

City or town Des Moines

State or country Iowa

Born - May - 10 - 1870.

RECEIVED APR 26 1929

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MAR 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65393

PLACE OF DEATH

County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14

2. FULL NAME Nathaniel Robertson

(a) Residence. No. Plano Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Jeanette Stockfield Robertson

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	10	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Thomas Robertson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Mary Ann Cubbatt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Nathaniel Robertson
(Address) Plano Idaho

15. Filed 3/16, 1929 J Rymonn Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2, 3, 1929, to 2, 7, 1929, that I last saw h— alive on 2, 8, 1929, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. Bennett, M. D.
2-14-1929 (Address) St Anthony

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Plano	2-15-1929

20. Undertaker	Address
A B Eckersell	Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65394

PLACE OF DEATH

County of ~~Rexburg~~ Madison

City of Rexburg

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 15

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Esther Nichols

(a) Residence. No. Rexburg - 2nd west St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.M.

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Quincy B. Nichols

6. DATE OF BIRTH (month, day and year) Sept 2/1894

7. AGE Years 34 Months 5 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Louis Howell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa USA

12. MAIDEN NAME OF MOTHER Sarah E. Gunnell

13. BIRTHPLACE OF MOTHER ~~(city or town)~~ (State or Country) Utah

14. Informant Sarah Howell
(Address) Rexburg Idaho

15. Filed 2/17, 1929 J. Wyoming Registrar

Shipped Feb 17 - 29

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1929, to Feb. 14, 1929

that I last saw her alive on Feb. 14, 1929

and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows: Streptococci Infection of Rt. thigh, Septicemia, etc.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. B. Rigby, M. D.

Feb 16, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. ~~Place of Burial, Cremation,~~ or Removal Salt Lake City - Utah — Date of Burial 2/18 1929

20. Undertaker A. B. Eckersell — Address Rexburg

RECEIVED MAR 14 1929

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 65395
Registered No. 16

1. PLACE OF DEATH.
County of Madison
City of Rexburg (No. 9, St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George McArthur

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 7 (Day) 1878 (Year)

7. AGE: 50 yrs. 10 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John D. McArthur

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Sarah Abbott

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs George McArthur
(Address) St. Anthony Idaho

15. Filed 3/20/ 1929 J Nyman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1929, to Feb. 17 1929, that I last saw h.. alive on Feb. 17 1929, and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:
Peritonitis, Ruptured Appendicitis, General Peritonitis.
(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) A B Rigby M. D.
Feb 18 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: St. Anthony Idaho | DATE OF BURIAL: Feb 21 1929

20. UNDERTAKER: W. M. Hansen | ADDRESS: St. Anthony Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 1976O

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65396

PLACE OF DEATH

County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

2. FULL NAME Wanda Dea Christenson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb -16-1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Oscar P. Christinsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Stockholm Sweeden
12. MAIDEN NAME OF MOTHER Eliza A. Bramwell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Portage Utah

14. Informant Oscar P Christenson
(Address) Hamer Idaho

15. Filed 3/23, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2-22-1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1929, to Feb 22, 1929, that I last saw her alive on Feb 22, 1929, and that death occurred, on the date stated above, at 130 P. m.

The CAUSE OF DEATH* was as follows:
Pyloric Stenosis
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Premature Birth
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) Louis A Ricks, M. D.
2-23, 1929 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg	Feb-24 1929
20. Undertaker	Address
Olivin Fellow	Rexburg

RECEIVED MAR 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65397

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100.
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 18

2. FULL NAME Nathan Salsbury

(a) Residence. No. 76-W. Main St. Gooding Ida
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Fannie Salsbury

6 DATE OF BIRTH (month, day and year) Oct 21-1844

7 AGE 84 Years | Months 4 | Days 14 | If LESS than 1 day, ✓ hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Member G.A.R. Former P.M. Gooding Ida
(c) Name of employer US.

9 BIRTHPLACE (city or town) (State or country) Ogle Co. Illinois

PARENTS
10 NAME OF FATHER Wm Clark Salsburg
11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont
12 MAIDEN NAME OF MOTHER Baleria Ann Wilder
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio.

14 Informant Mrs. Claud L. Miller
(Address) Rexburg Idaho

15 Filed 3/6, 1928 J V Young Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 5 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1929, to March 5, 1929, that I last saw him alive on March 5, 1929, and that death occurred, on the date stated above, at 9 20 AM.

The CAUSE OF DEATH* was as follows:
Myocarditis - chronic
(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Anemia - (pernicious)
(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? place of death
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? symptoms
(Signed) Louis F Rich M. D.
3-5, 1929 (Address) Rexburg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Gooding Ida. | Date of Burial 3/8 1929

20. Undertaker A B Eckersell | Address Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 14 1929

PLACE OF DEATH

County of Madison

City of Rexburg

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65398

Local Registrar's No. 19

2. FULL NAME Ryland H Machen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 5/29

7. AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rexburg Idaho

PARENTS

10. NAME OF FATHER Ryland G Machen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rexburg Idaho

12. MAIDEN NAME OF MOTHER Josephine E Hartzog

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant [redacted] Rexburg
(Address) R F D Rexburg

15. Filed 3/6, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 5, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5, 1929, to March 5, 1929
that I last saw him alive on March, 1929
and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Premature (6½ Mos.)
Lived only a few minutes.
No known cause of Premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

March 5, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker C O Eckersell | Address Rexburg

RECEIVED MAR 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65399

PLACE OF DEATH
County of Madison
City of Salem

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

2. FULL NAME Remona Fay Warden

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years | Months | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Fay Ernest Warden
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jamieson Utah - Sanpete
12. MAIDEN NAME OF MOTHER Emma James
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rock Valley Box Elder - Utah

14. Informant Fay Evaston
(Address)

15. Filed 3/6, 1929 J Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1929, to Mch 4, 1929
that I last saw her alive on Mch 4, 1929
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:
Duration.

..... (duration) ..... yrs. ..... mos. 7. ds.

CONTRIBUTORY (Secondary) Premature birth.

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Race of death
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) Lorin F. Rich, M. D.
3 - 5, 1929. (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rexburg | Date of Burial 19

20. Undertaker Morris Keller | Address Rexburg.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 5 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 65400

Registered No. 19

Registration District No. 19

Primary Registration District No. 2015

1. PLACE OF DEATH

County of Minidaka

City of Rupert

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Humphries

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~(Write the word.)~~ S

6. DATE OF BIRTH: Dec (Month) 24 (Day) 1928 (Year)

7. AGE: Yrs. 3 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. L. Humphries

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Lena Martindale

13. BIRTHPLACE OF MOTHER (State or Country): ~~Don't Know~~ Oakley, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Humphries
(Address) Rupert Idaho

15. Filed 4 - 3 1929 E. H. Elmore
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21 1928, to Mar. 1 1929, that I last saw her alive on Feb. 28 1929, and that death occurred on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth,
and Inanition

(Duration) ..... Yrs. 2 mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. H. Elmore M. D.

4-3 1929 (Address) Rupert, Idaho,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Mar 2 1929

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert

APR 5 1929

CERTIFICATE OF DEATH

Registration District No. 19

County of Minidoka

Primary Registration District No. 2515

File No. 65401

City of Rupert (No. ..... St.)

Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Edna Newlon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1888 (Year)

7. AGE: 48 Yrs. 9 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: Thomas Jones

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Margaret Sanderson

(Address) Rupert Idaho

15. Filed 4-3 1929

E H Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 18 1928, to Feb. 14 1929, that I last saw her alive on Feb. 13 1929, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia Progressive

..... (Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senetic Gummis

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) E H Elmore M. D.

4-3 1929 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cem

DATE OF BURIAL: Feb 17 1928

20. UNDERTAKER: W. A. Goodman

ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19 RECEIVED APR 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

File No. 65402

Registered No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry A. Reisinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH: Mar (Month) 15 (Day) 1856 (Year)

7. AGE: 72 Yrs. 11 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kyrle Otis Reisinger

(Address) Rupert Idaho

15. Filed 4-3 1929

E. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1929, to Feb 28 - 1929, that I last saw him alive on Feb 28 1929, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Bright Disease

about (Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio Sclerosis

about (Duration) 5 yrs. ..... mos. ..... ds.

(Signed) Lelon Frazier M. D.

..... 19 ..... (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery

DATE OF BURIAL: Mar 3 1929

20. UNDERTAKER: W. A. Goodman

ADDRESS: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 1-19. D APR 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Paul

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

File No. 65403

Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John M Watson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Oct (Month) 3 (Day) 1856 (Year)

7. AGE: 72 Yrs. 4 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: James Watson

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Rachel

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mathis Watson

(Address) Paul Idaho

15. Filed 4-8 1929 E H Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1929, to Feb 28 1929 that I last saw him alive on Feb 28 1929, and that death occurred on the date stated above, at 2 00 p M.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

about

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leland Ingert M. D.

19..... (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paul Cemetry

DATE OF BURIAL: Mar 2 1929

20. UNDERTAKER: W. A. Goodman

ADDRESS: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 1 6 1929

PLACE OF DEATH

County of Nezperce

City of Culdesac

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 128

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65405

Local Registrar's No.

2. FULL NAME Homer Adolphus Davis

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 7, 1910

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	1	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Malten Mo

PARENTS

10. NAME OF FATHER Ben H Davis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Williamson Ill

12. MAIDEN NAME OF MOTHER Martha Welch

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Butler County Mo

14. Informant Ben A Davis

(Address) Culdesac.

15. Filed Jan, 1929 George Gaspard M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1928, to Jan 4, 1928 that I last saw him alive on Jan 4 1928 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Gaspard, M. D.

Jan, 1929 (Address) Culdesac Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Culdesac, Ida.	1/5/29 19

20. Undertaker	Address
H.R.Merchant	Clarkston Wn

FORM V. S. No. 5-25 M. 1-19.

MAR 16 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65406

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce

City of Spalding Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

2. FULL NAME Mrs Charles Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH ..... (Month) ..... (Day) ..... (Year)

7. AGE: 56 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Yelma Houchoute

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Tomi Komny

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Williams

(Address) Spalding Idaho

15. Filed Jan 1929 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-29-1928, to 1-7-1929, that I last saw her alive on 1-6-1929 and that death occurred on the date stated above, at 6:40 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaignard M. D.

1/7/1929 (Address) Goldsac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spalding Idaho

DATE OF BURIAL: 1-8-1929

20. UNDERTAKER: Brower-Wann

ADDRESS: Lewiston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

MAR 16 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65407

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce

City of Lapwai Idaho.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. St.)

2. FULL NAME Mary Jefferson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: 11 (Month) 25 (Day) 1928 (Year)

7. AGE: 4 Yrs. 1 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father: Joe Jefferson

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER: Cecilia Raymond

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cecilia Raymond

(Address) Lapwai Idaho.

15.

Filed Jan 1929 George Gaymard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1929 to Jan 16 1929

that I last saw her alive on Jan 16 1929

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaymard M. D.

Jan 1929 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Slickpoo Mission

DATE OF BURIAL: 1-18-1929

20. UNDERTAKER: Brower-Wann

ADDRESS: Lewiston Ida.

RECEIVED MAR 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65408

PLACE OF DEATH

County of Nez Perce
City of Lewiston Webb

Registration District No. 128
Primary Registration District No.
Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ida Pearl Gustin

(a) Residence. No. St. Webb, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: A. J. Gustin

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 44 | Months — | Days 29 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hastings Neb.

PARENTS

10. NAME OF FATHER: C. A. Gummere
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Florence Huston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: A. J. Gustin
(Address): Webb, Idaho

15. Filed Jan, 1929 George Gaignard M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19
that I last saw her alive on Jan 24, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Geo O Keck, M. D.
Jan 25, 1929 (Address) Lapwai Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho | Date of Burial: 1/27 1929

20. Undertaker: Brower-Wann Co | Address: Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65409

Local Registrar's No.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH MAR 16 1929

County of Nez Perce — Registration District No. 128

City of Lapwai Idaho — Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information. (No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Indian 4/4	Widowed

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE — 90 Yrs. ..... Mos. ..... ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF Father: Allen

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Tash a hoh poo

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Abel Grand
(Address) Lapwai Idaho.

15. Filed Jan 1929 George Gaignard Local Registrar

MEDICAL CERTIFICATE OF DEATH 31

16. DATE OF DEATH: Jan (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-24-, 1929, to 1-26- 1929
that I last saw h[illegible] alive on 1-26- 1929,
and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaignard M. D.
1/26/1929 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lapwai Idaho — DATE OF BURIAL 1-28- 1929

20. UNDERTAKER — ADDRESS

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

April 22, 1929

RECEIVED APR 29 1929

Dr. George Gaignard

Culdesac, Idaho.

Re: 65409

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Joseph Allen who died Jan. 26, 1929.

Information DESIRED in order to complete certificate:

Was he SINGLE, MARRIED, WIDOWED or DIVORCED?

PLEASE ANSWER BELOW:

Widowed.

Dr. George Gaignard

RECEIVED MAR 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65411

PLACE OF DEATH
County of Nez Perce
City of near Culdesac Idaho
Registration District No. 128
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs John Carter Ford
(a) Residence. No. Asotin Wash. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: John Carter Ford
6. DATE OF BIRTH (month, day and year)
7. AGE: 37 Years | Months: 10 | Days: 20 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —
9. BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS
10. NAME OF FATHER: William Bolick
11. BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina
12. MAIDEN NAME OF MOTHER: Rapey Green
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): North Carolina

14. Informant: John Carter Ford
(Address): Asotin Wash.
15. Filed Feb, 1929 George Gaigneed Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec, 1927, to , 19
that I last saw h[illegible] alive on Dec, 1927
and that death occurred, on the date stated above, at 8:30 P. m.
The CAUSE OF DEATH* was as follows:
Paraplegia.
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Asotin Wash
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) George Gaigneed M. D.
Feb 1929 (Address) Culdesac Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Culdesac Idaho — Date of Burial: Feb 7 1929
20. Undertaker: Brewer-Mann — Address: Lewiston Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D Gaisnard

RECEIVED MAR 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65412

PLACE OF DEATH
County of Nez Perce
City of Sweetwater

Registration District No. 128
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Louise James Redlock Red Elk

(a) Residence. No. Sweetwater St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Indian
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Silas Redlock

6. DATE OF BIRTH (month, day and year) Sept - 1911

7. AGE Years 18 Months — Days - If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweetwater Idaho

PARENTS

10. NAME OF FATHER Louis James
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Thusea James
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweetwater Idaho

14. Informant Jewell Jackson
(Address) Sweetwater

15. Filed Feb 19 1929 George Gaisnard M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-29-, 1927, to 2-3-, 1929
that I last saw her alive on 2-3-, 1929
and that death occurred, on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) 1 yrs. 2 mos. 6 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) George Gaisnard, M. D.
Feb 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mission Cemetery — Date of Burial: 2-6-1929
20. Undertaker: Vassar Und Co — Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAR 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Nez Perce

City of near Culdesac Idaho

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

State File No. 65413

Local Registrar's No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Barbara Hasenoehrl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): ~~Married~~ Widowed

6. DATE OF BIRTH: Feb (Month) 24 (Day) 1853 (Year)

7. AGE: 75 Yrs. 11 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Austria

10. NAME OF Father: Denk

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Nat Known

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Hasenoehrl
(Address) Culdesac Idaho

15. Filed Feb 1929 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 18 (Day) 1929 (Year)

17. Sept I HEREBY CERTIFY, That I attended deceased from Oct 28 19..., to ..... 19..., that I last saw her alive on Sept 1928 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis

(Duration) 10 yrs. ..... mos. ..... ds.

Contributory (Secondary): Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) George Gaignard M. D.

2/18/1929 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shickpoo Mission

DATE OF BURIAL: 2/20 1929

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 6-A (-25 M. 1-19) RECEIVED MAR 16 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 65414

Registered No.

1. PLACE OF DEATH

County of Nez Perce

City of Spalding

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dave Outerhout

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Sept (Month) 24 (Day) 1847 (Year)

7. AGE: 81 Yrs. 4 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. L. Pierce

(Address)

15. Filed Feb 1929 George Gaugnard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 21st (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19th 1929, to Feb 21st 1929 that I last saw him alive on Feb 19 1929 and that death occurred on the date stated above, at 9 10 A.M.

The CAUSE OF DEATH* was as follows:

apoplexy - (Cerebral Haemorrhage)

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Arteriosclerosis & High blood pressure

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) E. L. White M. D.

2-21 1929 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Deary Ida

DATE OF BURIAL 19

20. UNDERTAKER: E. H. Irwin Palouse Wash

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65415

PLACE OF DEATH

County of Nez Perce.

City of Culdesac.

Registration District No. 128

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Harrison Coan.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 13th, 1845.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83.	7.	11.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana.

PARENTS

10. NAME OF FATHER John Coan.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Margaret -------.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant O. C. Coan.
(Address) Culdesac, Idaho.

15. Filed Feb. 19 29 George Geismard M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 24th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1929, to Feb 24, 1929
that I last saw h alive on Feb 22, 1929
and that death occurred, on the date stated above, at 10:10 P. m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 14 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Geismard M. D.
2/26/29. 19 (Address) Culdesac, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	2/27/29. 19
20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65528

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Beulah Fay Bates

(a) Residence. No. 226 - 7th St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of C B. Bates

6. DATE OF BIRTH (month, day and year) Sept 15 - 1902

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	4	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Geo. E. McWhite
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Elizabeth
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant C B. Bates
(Address) Lewiston

15. Filed Feb 9, 1929 Simon E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH 138

16. DATE OF DEATH Jan 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21, 1929, to Jan 26, 1929
that I last saw her alive on Jan 26, 1929
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows: Acute Salpyngitis & pelvic abscess

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of Jan 21-29
Was there an autopsy? no
What test confirmed diagnosis? Operation
(Signed) Paul B Johnson M. D.
1/26, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Centralia Wash — Date of Burial 19

20. Undertaker Vassar Bud Co — Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65529

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1809
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Sumner Richardson

(a) Residence. No. 0123 27th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Ella Richardson

6. DATE OF BIRTH (month, day and year) Apr. 1st 1905

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	9	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Cottonwood
(State or country) Idaho

PARENTS

10. NAME OF FATHER J. B. Richardson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine
12. MAIDEN NAME OF MOTHER Lena Barnes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Mrs. Lena Richardson
(Address) Lewiston, Idaho

15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19..., to ✓, 19...
that I last saw h ✓ alive on ✓, 19...
and that death occurred, on the date stated above, at ...m.
The CAUSE OF DEATH* was as follows: Strychnine Poisoning
Suicide.
(duration) yrs. mos. ds.
CONTRIBUTORY ✓
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E M Bowyer Coroner M. D.
1/28, 1929 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or Removal	Date of Burial
Lewiston Idaho	1/28 1929
20. Undertaker	**Address**
Bowyer-Mann Co.	Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65530

PLACE OF DEATH
County of Nezperce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Josephs Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Emly Florence Warren

(a) Residence. No. St. Clarkston Wash
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 29, 1928

7. AGE Years	Months	Days	If LESS than 1 day,
	3	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clarkston, Wash

PARENTS

10. NAME OF FATHER J.K. Warren

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Troy Idaho

12. MAIDEN NAME OF MOTHER Elsie Craig

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Westlake, Idaho

14. Informant J.K. Warren
(Address) Clarkston, Wash.

15. Filed Feb 9, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1929, to Jan 27, 1929
that I last saw her alive on Jan 27, 1929
and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Congenital heart lesion
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Clarkston Wash
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) Paul V Johnson, M. D.
Jan 29, 1929 (Address) Clarkston Wash

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	1/29/29 19

20. Undertaker	Address
H.R. Merchant	Clarkston Wn

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65531

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME O. B. Waymire
(a) Residence. No. ..... St. Stites Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 11 - 1887

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
41	10	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Forester
(b) General nature of industry, business, or establishment in which employed (or employer) Employ U S Government
(c) Name of employer U.S.A.

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS
10. NAME OF FATHER John A Waymire
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oregon
12. MAIDEN NAME OF MOTHER Jennie Palmein
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn

14. Informant Mrs O B Waymire
(Address) Stites Ida

15. Filed Feb 9, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH 117

16. DATE OF DEATH Jan (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1929, to Jan 27, 1929
that I last saw him alive on Jan 27th 1929
and that death occurred, on the date stated above, at 4 30 p.m.
The CAUSE OF DEATH* was as follows:

Acute General Peritonitis
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Ruptured Appendix
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Jan 22/29
Was there an autopsy? No
What test confirmed diagnosis? True Pus over whole abdomen
(Signed) Jos Carnow, M. D.
Jan 28th, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grangeville Ida
Date of Burial 19

20. Undertaker: Vassar Und Co
Address: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Dr Clark RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65532

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Henry Massam

(a) Residence. No. St. Elk City Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 11 - 1867

7. AGE Years 61 Months 8 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining
(b) General nature of industry, business, or establishment in which employed (or employer) Gold mining
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS
10. NAME OF FATHER John Massam
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Ann. Houston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant John Massam Jr.
(Address) Elk City Idaho

15. Filed Feb 9, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

90

16. DATE OF DEATH Jan (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1928, to Jan 28, 1929
that I last saw him alive on Jan 28, 1928
and that death occurred, on the date stated above, at 10:00 p.m.
The CAUSE OF DEATH* was as follows:
Chronic Valvular
Heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis -

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. Clark, M. D.
Jan 31, 1928 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston
Date of Burial 19

20. Undertaker Vassar Und Co
Address Lewiston

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65533

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Harry Teale Pratt. 96

(a) Residence. No. 1702 8th, Avenue. 1009 Sex
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 10/8/1878.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50.	3.	21.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Oiler.

(b) General nature of industry, business, or establishment in which employed (or employer) Saw mill.

(c) Name of employer Clearwater Timber Company.

9. BIRTHPLACE (city or town) Calistoga.
(State or country) California.

PARENTS

10. NAME OF FATHER Eugene Pratt.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois.

12. MAIDEN NAME OF MOTHER Emma Teale.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant
(Address) Lewiston, Idaho.

15. Filed Feb 9, 1929 Brian E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH 111-a

16. DATE OF DEATH
January 29th, 1929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1929, to Jan 29, 1929, that I last saw h~~im~~ alive on Jan 28, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Acute General Peritonitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Perforated Gastric Ulcer (duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Jan 22 1929

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E E Broadbent, M. D.
1/31/29, 19 (Address) Lewiston, Odaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ontario, Oregon.	19

20. Undertaker	Address
Brower-Mann Company.,	Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65534

PLACE OF DEATH

County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
No. St Joseph Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Owen C Hooper.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: June 7. 1882
6. DATE OF BIRTH (month, day and year): ~~Jan 1 1929~~
7. AGE — Years: 46 | Months: 6 | Days: 24 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer): farming
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10. NAME OF FATHER: Wm Hooper
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wash
12. MAIDEN NAME OF MOTHER: Louella Marshall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Mrs Haggan
(Address): Moscow Ida
15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 1 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1928, to Jan 1, 1929
that I last saw h~~im~~ alive on Jan 1, 1929
and that death occurred, on the date stated above, at 1130P m.
The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ~~c~~
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Ed Broadbent, M. D.
Jan 3, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Ida — Date of Burial: 1/3 1929
20. Undertaker: Vassar Und Co — Address: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

OWEN E. HOOPER who died January 1st, 1929. at St. Joseph Hospital

Information DESIRED in order to complete certificate:

Was he SINGLE, MARRIED, WIDOWED or DIVORCED?

PLEASE ANSWER BELOW:

Owen E. Hooper was widowed as his wife died the day before him namely Dec 31 1928

E. G. Broadnax

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65535

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. ~~96~~ 95
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Frances David 96
(a) Residence. No. Pierce Idaho St. Pierce Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 2 1916

7. AGE Years 12 Months 11 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mont.

PARENTS
10. NAME OF FATHER Henry David
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada.
12. MAIDEN NAME OF MOTHER Gertrude Barrill
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mont.

14. Informant Henry David
(Address) Pierce Idaho

15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH 128

16. DATE OF DEATH Jan (Month) 3rd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 31st, 1928, to Jan 3rd, 1929
that I last saw her alive on Jan 3rd, 1929
and that death occurred, on the date stated above, at 6 a.m.
The CAUSE OF DEATH* was as follows:
Subacute Parenchymatous
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Missoula Mont
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Urine
(Signed) O C Marsson M. D.
, 19 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 1/3/ 1929

20. Undertaker Vassar Kind Co.
Address Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65536

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 16
Primary Registration District No. 1009
Local Registrar's No.
(No. White Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace England.

(a) Residence. No. 1426 Main St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of W. H. England.

6. DATE OF BIRTH (month, day and year) 10/29/1909.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
19.	2.	4.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bedford county, Virginia.

PARENTS

10. NAME OF FATHER R. B. Carroll.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia.
12. MAIDEN NAME OF MOTHER Ida ---------.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia.

14. Informant W. H. England
(Address) Lewiston, Idaho.

15. Filed Jan 9, 1929 Susan E. Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH 10-a

16. DATE OF DEATH
January 3rd, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Jan 3, 1929
that I last saw her alive on Jan 3, 1929
and that death occurred, on the date stated above, at 9:30 A. m.
The CAUSE OF DEATH* was as follows:

Pneumonia Lobar.
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Flu
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. White, M. D.
1/4/29, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Roanoke, Va. Date of Burial 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65537

PLACE OF DEATH

County of Nezperce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Wesley Yabsley

(a) Residence. No. 0106 - 2 9 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 16, 1927

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	3	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ione, Wash

PARENTS

10. NAME OF FATHER Chas Wesley Yabsley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ontario, Canada
12. MAIDEN NAME OF MOTHER Pearl May Hewitt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ontario, Canada

14. Informant G W Yabsley
(Address) Lewiston, Ida.

15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1928, to Jan 5, 1929
that I last saw h[illegible] alive on Jan 5, 1929
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Meningitis (Influenzal?)
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Flu
(duration) yrs. mos. 15 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms.
(Signed) E. L. White, M. D.
1-5-, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Ida.	19

20. Undertaker H.R.Merchant Address Clarkston Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65538

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Benj Franklin Taylor.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 4 - 1860

7. AGE — Years: 68 | Months: 9 | Days: 2 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): California

PARENTS

10. NAME OF FATHER: Benj F Taylor.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ky
12. MAIDEN NAME OF MOTHER: Esther Huling
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: Mrs Emerick
(Address): Lewiston Orchards

15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan Dec 31, 1928, to Jan 6, 1929
that I last saw h~~im~~ alive on Jan 6 -, 1929
and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Flu

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M. D.
1-7, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Spokane Wn	
20. Undertaker	Address
Vassar Und Co	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Benj. Franklin Tayler who died Jan. 6, 1929 at White's hospital.

Information DESIRED in order to complete certificate:

Was he ~~single~~, married, widowed ~~or divorced~~?

PLEASE ANSWER BELOW:

Widowed

E. L. White - M. D.

65538

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65539

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.

PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Junior Jackson
(a) Residence No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 6 - 1921

7. AGE	Years	Months	Days	If LESS than 1 day,
	7	10	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Wm H Jackson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER June Durant
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant Wm H Jackson
(Address) Lewiston

15. Filed Feb 9, 1929 Susan E Brune Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1929, to Jan 6, 1929
that I last saw h[illegible] alive on Jan 6, 1929
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Meningitis.
(Meningococcus.) Laboratory Finding
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Flu.
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory & Symptoms Confirmed
(Signed) E. L. White, M. D.
1-7, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	1/8, 1929
20. Undertaker	Address
Vassar Mtd Co	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65540

PLACE OF DEATH
County of Nez Perce.
City of Lewiston.

Registration District No. 96
Primary Registration District No. 1009
(No. 638 10th, Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Martha Ellen Coffey.

(a) Residence. No. 638 10th, Street St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 7/23/1845.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83.	5.	16.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri.

PARENTS

10. NAME OF FATHER George Phillips.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Not known.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant B.C. Coffey.
(Address) Lewiston, Idaho.

15. Filed Feb 9, 1929 Susan E. Brucc
Registrar

MEDICAL CERTIFICATE OF DEATH

15

16. DATE OF DEATH
January 9th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 15. 1928, to Jan 9 1929
that I last saw h[illegible] alive on Jan 8 1929
and that death occurred, on the date stated above, at 1:00 a.m.

The CAUSE OF DEATH* was as follows:

General Septicemia

(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) General Paralysis
(duration) yrs. 5 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? yes
What test confirmed diagnosis? Physical Signs

(Signed) [illegible], M. D.
1/10/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	1/10/29. 19

20. Undertaker	Address
Brower-Wann Company	Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65542

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. White Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Te with le pun, Wan mit.

(a) Residence. No. St. Lapwai, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: Indian 4/4
5. Single, Married, Widowed, or Divorced (write the word): Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 50 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Washington.

PARENTS

10. NAME OF FATHER: Not known.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wash.
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wash.

14. Informant: Paul Ambrose
(Address): Lapwai, Idaho.

15. Filed Feb 9, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

101-0

16. DATE OF DEATH: January 11th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31, 1928, to Jan 11th, 1929
that I last saw her alive on Jan 11, 1929
and that death occurred, on the date stated above, at 10:45 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar ?)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 15 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M. D.
Jan. 14th, 1929. (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lapwai, Idaho.	1/14/29. 19
20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65543

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. W 2nd.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Leong Way
(a) Residence. No. 1 W 2nd St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Chinese	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) —

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) China

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Vassar Hrd Co.
(Address) Lewiston Idaho.

15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1929, to Jan 5, 1929
that I last saw her alive on Jan 5, 1929
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach & Liver
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Senile
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms.
(Signed) E. L. Wyatt, M. D.
1-15-, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho.	1/13 1929
20. Undertaker Vassar Hrd Co.	Address Lewiston Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65544

PLACE OF DEATH

County of Nezperce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Benjiman Franklin Kerr

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Erma Summerland

6. DATE OF BIRTH (month, day and year): July 11, 1901

7. AGE: Years 27, Months 6, Days 2. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Lura Kansas

PARENTS

10. NAME OF FATHER: Thomas J Kerr

11. BIRTHPLACE OF FATHER (city or town) (State or Country): White County Tennessee

12. MAIDEN NAME OF MOTHER: Ida M Bronson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Lucas, Russell Co. Kansas,

14. Informant: TJ Kerr
(Address): Clarkston, Wash.

15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH 101 a

16. DATE OF DEATH: Jan (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-22, 1928 to Jan-13, 1929

that I last saw him alive on Jan 12, 1929

and that death occurred, on the date stated above, at 9-15 a m.

The CAUSE OF DEATH* was as follows:

Pleuro Pneumonia
empyema
Lobe Pneumonia

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J M Lyle M. D.

Jan 14, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clarkston, Wn. Date of Burial: Jan 15 1929

20. Undertaker: H.R. Merchant Address: Clarkston Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65545

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 95
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Clarence David Dunlap

(a) Residence. No. ..... St. Culdesac, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 10/18/1902

7. AGE: 26 Years | Months: 2 | Days: 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Bridge Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: Camas Prairie R.R. Co.

9. BIRTHPLACE (city or town) (State or country): Ft. Collins Colorado

PARENTS

10. NAME OF FATHER: David Dunlap
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Mary Hersler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dresden Germany

14. Informant: Waldo Dunlap
(Address) Culdesac Idaho

15. Filed Feb 9, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH 185

16. DATE OF DEATH: Jan. 17th (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Fractured Skull
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Accidental (falling from bridge at Moses Wash.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Physical Signs
(Signed) William P. Hatch, M. D.
1/17, 1929 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho | Date of Burial: 1/20/1929

20. Undertaker: Brower-Wann Co | Address: Lewiston, Idaho

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65546

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.

PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Laura Bisson
(a) Residence. No. Clarkston Wash 521-1 10th St. Clarkston Wash
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 5 ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John A Bisson

6. DATE OF BIRTH (month, day and year) Feb 7 - 1879

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	49	11	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER John La Montany
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Anniate Lerroy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant John A Bisson
(Address) Clarkston Wash

15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH 14a

16. DATE OF DEATH: Jan (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16, 1929, to Jan 19, 1929, that I last saw her alive on Jan 19, 1929, and that death occurred, on the date stated above, at 3 PM m.,
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Arterio Hypertension
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) L Blockenagen, M. D.
Jan 21, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Coeur d Alene Idaho	1929
20. Undertaker: Vassar Bud Co.	Address: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65547

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1069

Local Registrar's No.

(No. 0215 - 25th St.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Huckabay

(a) Residence. No. 0215 - 25th St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 3/14/1893

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35	10	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Truck driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Star Dray Co.

9. BIRTHPLACE (city or town) (State or country) Wash

PARENTS

10. NAME OF FATHER Edward R.L. Huckabay

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known

12. MAIDEN NAME OF MOTHER Frances Burgess

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant Victor Huckabay

(Address) Clarkston Wash.

15. Filed Feb 9, 1929 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 20th 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1929, to Jan 20, 1929
that I last saw h~~im~~ alive on Jan 20, 1929
and that death occurred, on the date stated above, at 11 a.m.
The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Ed Broadbeck, M. D.

1/21, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Colfax, Wash.	

20. Undertaker Address

Brower - Mann Co. Lewiston, Idaho

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65548

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. 716-10th st.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ferdinand Roos Sr.

(a) Residence. No. 716 10th St St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 1 - 1850

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	—	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER John P. Roos.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Katherine Young.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant J P Roos Jr
(Address) Lewiston

15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH 129

16. DATE OF DEATH Jan 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Jan 22, 1929
that I last saw him alive on Jan 21, 1929
and that death occurred, on the date stated above, at 5 a.m.
The CAUSE OF DEATH* was as follows: Chronic Nephritis

(duration 3 yrs. mos. ds.)

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible] M. D.
1/23, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	1/23 1929

20. Undertaker Vassar Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Braddock

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65549

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Theresa Wren.

(a) Residence. No. St. Culdesac, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of I. Q. Wren

6. DATE OF BIRTH (month, day and year) 6/19/1878.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50.	7.	3.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Spencer,
(State or country) Iowa.

PARENTS

10. NAME OF FATHER James Peterson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.
12. MAIDEN NAME OF MOTHER Necolen Larsen.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway.

14. Informant I. Q. Wren.
(Address) Culdesac, Idaho.

15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 22nd, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1929, to Jan 22, 1929
that I last saw h~~e~~ alive on Jan 21, 1929
and that death occurred, on the date stated above, at 5 30 A m.
The CAUSE OF DEATH* was as follows:

Peritonitis acute
(duration) yrs. mos. 9 ds.
CONTRIBUTORY (Secondary) acute appendicitis
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? Culdesac Idaho
Did an operation precede death? yes Date of Jan 13 1929
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Earl Braddock, M. D.
1/22/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Culdesac, Idaho.	1/25/29. 19
20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Lyle

DO NOT WRITE IN THIS SPACE
State File No. 65550

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hattie E. Wright.

(a) Residence. No. St. Sweetwater, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Samuel Wright.

6. DATE OF BIRTH (month, day and year) 3/25/1872.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56.	9.	26.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER John Walker

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Emaline Ragen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant W. Wright
(Address) Anacortes, Wash.

15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

10 A

16. DATE OF DEATH January 22nd, 1929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 29, to Jan 22 19 29
that I last saw h alive on Jan 22 19 29
and that death occurred, on the date stated above, at 6 m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. W. Lyle, M. D.
1/23/29, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	1/26/29. 19
20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65551

PLACE OF DEATH

County of Nezperce.

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William E Stoddard

(a) Residence. No. 312 Prospect Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Richards

6. DATE OF BIRTH (month, day and year) June 28-1869

7. AGE Years 59 Months 6 Days 25 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arlington, Mich.

PARENTS

10. NAME OF FATHER Sameul Stoddard

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Conn.

12. MAIDEN NAME OF MOTHER Hattie Moden

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs W. E. Stoddard

(Address) Lewiston, Ida.

15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH (13)

16. DATE OF DEATH Jan. (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1928, to Jan 23, 1929 that I last saw him alive on Jan 22, 1929 and that death occurred, on the date stated above, at 2.30 A.m.

The CAUSE OF DEATH* was as follows:

Uremia -

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertrophy of Prostate (duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Jan 21 1929

Was there an autopsy? No

What test confirmed diagnosis? Albumen cast + pus in urine

(Signed) Edgar Broadbent, M. D.

Jan 25, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston, Ida. Date of Burial Jan. 26 1929

20. Undertaker H. R. Merchant Address Clarkston Clarkston Ida

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65552

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lavern Frank Trail.

(a) Residence. No. North Lewiston. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 11/21st, 1928.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
[illegible]	2.	1.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston, Idaho.

PARENTS

10. NAME OF FATHER B. F. Trail.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Elsie Orcutt.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oklahoma.

14. Informant B.F. Trail
(Address) Lewiston, Idaho.

15. Filed Feb 9, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 23rd, 1929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 23, 1929, to Jan 23, 1929
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Deceased dead when first saw him from unknown cause.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. J. Braddock, M. D.

1/24/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	1/25/29. 19

20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Carsow

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65553

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 95
Primary Registration District No. 1009
(No.) Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Albert Carpenter

(a) Residence. No. Lewiston Orchards St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 25th 1894

7. AGE Years 34 Months 1 Days 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) Farming
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Wesley K Carpenter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Effie Hopkins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Wesley Carpenter
(Address) Lewiston Orchards

15. Filed Feb 9, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH 129

16. DATE OF DEATH Jan (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17th, 1929, to Jan 24th, 1929
that I last saw him alive on Jan 24th, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

chronic Parenchymatous nephritis
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Dont Know
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? By urine examination
(Signed) Dr Carsow M. D.
1/26th, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker Vassar Und Co Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65554

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. 1318 G. Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Caroline L. Rowden.

(a) Residence. No. 1318 G. Street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Isaac Rowden.

6. DATE OF BIRTH (month, day and year) 10/4/1846.

7. AGE Years	Months	Days	If LESS than 1 day,
82.	3.	29.	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri.

PARENTS

10. NAME OF FATHER Alexander Clark.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.
12. MAIDEN NAME OF MOTHER Minerva Davidson.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant J. M. Hardin
(Address) Lewiston, Idaho.

15. Filed Mar 10, 1929 Wm E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH 90

16. DATE OF DEATH
February 3rd, 1929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1929, to Feb 3rd, 1929, that I last saw her alive on Feb 3rd, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Heart disease - Myocardial - acute dilitation.

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis.

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M. D.
2/5/29, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	2/6/29. 19
20. Undertaker	**Address**
Brower-Vann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

Mc Mahan.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65555

PLACE OF DEATH
County of Nez Perce.
City of Lewiston,
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 312 9th, Avenue.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oren Monroe Lanphear.

(a) Residence. No. 312 9th, Avenue. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 2/5/1851.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77.	11.	28.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired.
(b) General nature of industry, business, or establishment in which employed (or employer) Building contractor.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Watertown, Iowa.

PARENTS

10. NAME OF FATHER James Lanphear.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York.
12. MAIDEN NAME OF MOTHER Arilla Weeks.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York.

14. Informant Leslie Lanphear.
(Address) Lewiston, Idaho.

15. Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH 74-a

16. DATE OF DEATH
February 3rd, 1929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 1-27-, 1929, to 1-31-, 1929
that I last saw him alive on 1-31-, 1929
and that death occurred, on the date stated above, at 12:30 p m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. F. McMahan, M. D.
2/4/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane, Washington.	2/6/29. 19
20. Undertaker	**Address**
Brower-Wann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Johnson

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65556

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Lewis Barnett

(a) Residence No. 0127 - 22d St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Baby

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 3 - 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS

10. NAME OF FATHER R.A. Barnett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia
12. MAIDEN NAME OF MOTHER Edna Wolfe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Washington

14. Informant R.A. Barnett
(Address) 0127 - 22d St

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3, 1929, to Feb 4, 1929
that I last saw ~~him~~ alive on Feb 3, 1929
and that death occurred, on the date stated above, at 6 a.m.
The CAUSE OF DEATH* was as follows:
Probably enlarged Thymus Gland.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. + ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Paul W Johnson M. D.
2/4, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	2/4 1929

20. Undertaker Vassar Bros Co Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65557

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. St. Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert Williams.

(a) Residence. No. St. Melrose, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Divorced.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 7/2/1850.

7. AGE: 78. Years; Months: 7.; Days: 2.; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ontario, Canada.

PARENTS

10. NAME OF FATHER John Williams.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada.

12. MAIDEN NAME OF MOTHER Elizabeth --------/.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant Mrs C.H. Davies
(Address) Melrose, Idaho.

15. Filed, 19 Registrar

MEDICAL CERTIFICATE OF DEATH 103

16. DATE OF DEATH Feb. 4th, 1929. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1929, to Feb 4th, 1929 that I last saw him alive on Feb 4th, 1929 and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Malignant Odema

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) M

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Reubens, Idaho

Did an operation precede death? Moisture No Date of Feb 4th 29

Was there an autopsy?

What test confirmed diagnosis? Gangrene + presence pus

(Signed) O. Pearson, M. D.

2/4/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Melrose, Idaho. Date of Burial: 2/6/29. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

Baddock

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65558

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No.
Primary Registration District No.
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Jasper Newton Mounce

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Julia Mounce

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	73	5	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Joseph Mounce
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Christina Schue
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs J N Mounce
(Address) Lewiston Ida

15. Filed ____, 19____. Registrar

MEDICAL CERTIFICATE OF DEATH 89

16. DATE OF DEATH Feb (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Feb 4, 1929
that I last saw him alive on Feb 3, 1929
and that death occurred, on the date stated above, at 8 15 A m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) E G Broadbent, M. D.
Feb 11, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Lewiston Idaho	
20. Undertaker	Address
Vassar Und Co	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65559

PLACE OF DEATH

County of Nezperce
City of Lewiston
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Johnson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nonnattat Anderson

6. DATE OF BIRTH (month, day and year) Jan. 17 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65		18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Gardner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Mr Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Mathia
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Mrs Edward Johnson
(Address) Clarkston, Wash.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb Jan 16th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16th, 1928 to Feb. 5th, 1929
that I last saw him alive on Feb. 5th, 1929
and that death occurred, on the date stated above, at 4:45 P m.
The CAUSE OF DEATH* was as follows:
Aneurism of the arch of the Aorta

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. F. McMahan M. D.
, 19 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clarkston Cemetery	Feb 8 1929
20. Undertaker	**Address**
F. R. Merchant	Clarkston Wash

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. St. Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Lyc.

DO NOT WRITE IN THIS SPACE

State File No. 65560

Local Registrar's No.

2. FULL NAME Aaron Westling.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 11/2/1848.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80.	3.	4.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden.

PARENTS

10. NAME OF FATHER Nels Carlson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden.

12. MAIDEN NAME OF MOTHER Matilda --------.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden.

14. Informant Mrs A. M. Dennis
(Address) Lewiston, Idaho.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH 49

16. DATE OF DEATH
February 6th, 1929.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1927, to Feb-, 1929
that I last saw h- alive on Feb- 6, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Prostate - 1 yr.
(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. M. Feyle, M. D.
2/8/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	2/9/29. 19

20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65561

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Charles Bormeke
(a) Residence. No. St. Cameron, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Bormeke

6. DATE OF BIRTH (month, day and year) 12/22/1869

7. AGE Years 59 Months 1 Days 15 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hanover, Germany

PARENTS
10. NAME OF FATHER Joseph Bormeke
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Regina Schwartenberger
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs Anna Bormeke
(Address) Cameron, Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

90

16. DATE OF DEATH Feb 7th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1929, to Feb 7th, 1929
that I last saw him alive on Feb 5th, 1929
and that death occurred, on the date stated above, at 7 a.m.
The CAUSE OF DEATH* was as follows:
Valvular heart disease acute dilatation.
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Same
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. White, M. D.
2/9, 1929 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 2/9 1929

20. Undertaker Brown - Wann Co
Address Lewiston Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65562

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jennie E. McCracken.

(a) Residence. No. St. Culdesac, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of R. L. McCracken.

6. DATE OF BIRTH (month, day and year) 1/16/1874.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55.	----	21.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Silverton, Oregon.

PARENTS
10. NAME OF FATHER A. D. Polley.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin.
12. MAIDEN NAME OF MOTHER Virginia Paige.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin.

14. Informant R. L. McCracken
(Address) Culdesac, Idaho.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 7th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19th, 1929, to Feb 7th, 29
that I last saw h alive on Feb 7th, 29
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Intestinal & Pyloric Obstruction
(duration) yrs. + mos. ds.
CONTRIBUTORY (Secondary) Cancer Gall bladder Pylorus Stomach & Liver
(duration) yrs. + mos. ds.

18. Where was disease contracted if not at place of death? Culdesac Idaho
Did an operation precede death? Yes Date of Jan 31st 29
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) D. C. Crasson, M. D.
2/7/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Colfax, Washington.	
20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Carrow

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65563

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ralph Isly Skinner.

(a) Residence. No. 820 18th, Street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Myrtle Skinner.

6. DATE OF BIRTH (month, day and year): 12/29/1879.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49.	1.	9.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cement contractor.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10. NAME OF FATHER: Alfred Skinner.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Nova Scotia.
12. MAIDEN NAME OF MOTHER: Catherine Grawe.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois.

14. Informant: Mrs. Ralph Skinner
(Address): Lewiston, Idaho.

15. Filed ____, 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 8th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1928, to Feb 8th, 1929
that I last saw h[illegible] alive on Feb 8th, 1929
and that death occurred, on the date stated above, at 5 9 m.
The CAUSE OF DEATH* was as follows:

Pneumonia Relapsed
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary): Influenza
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Sputum Test
(Signed) C C Carrow, M. D.
2/11/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	2/11/29. 19
20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65564

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No.
Primary Registration District No.
Local Registrar's No.

(No. 222 10th, Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eugene S. Hicks.

(a) Residence. No. 222 10th, Street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	(?).

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not known.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68.			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not known.

PARENTS

10. NAME OF FATHER " "
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant G. P. Braun.
(Address) Lewiston, Idaho.

15. Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH 170

16. DATE OF DEATH
February 9th, 1929.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9th, 1929, to Feb 9th, 1929
that I last saw him alive on Feb 9, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Pistol bullet in brain thru Rt. temple to occiput
2 hours
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Suicide.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of Feb 9-29
Was there an autopsy? No
What test confirmed diagnosis? Findings at operation

(Signed) E. L. White, M. D.
2/15/29, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	2/15/29. 19
20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Lyle

DO NOT WRITE IN THIS SPACE

State File No. 65565

County of Nez Perce.

City of Lewiston.

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. St Joseph Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leslie E. Wishard.

(a) Residence. No. St. Genesee, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.

4. COLOR OR RACE White.

5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 14th, 1906.

7. AGE Years 22. Months 11. Days 26. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Peck. (State or country) Idaho.

PARENTS

10. NAME OF FATHER Bert Wishard.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Ella Green.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas.

14. Informant Bert Wishard

(Address) Genesee, Idaho.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH 65a

16. DATE OF DEATH February 10th, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-8, 1929, to Feb-10, 1929

that I last saw him alive on Feb. 10, 1929

and that death occurred, on the date stated above, at 1-15 P m.

The CAUSE OF DEATH* was as follows:

Leukemia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. M. Lyle, M. D.

2/11/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Genesee, Idaho. Date of Burial 2/13/29. 19

20. Undertaker Brower-Wann Company. Address Lewiston, Idaho.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65566

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Moses S. McMurray.

(a) Residence. No. St. Lewiston Orchards.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Cora McMurray.

6. DATE OF BIRTH (month, day and year) 2/8/1862.

7. AGE Years	Months	Days	If LESS than 1 day,
67.	----	7.	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Orchardist.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Springfield, xxx Illinois.

PARENTS

10. NAME OF FATHER William McMurray.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois.

12. MAIDEN NAME OF MOTHER Barbara Ann Bowman.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Mrs M.S. McMurray
(Address) Lewiston, Idaho.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 15th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W.B. Clark, M. D.
2/17/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	2/18/29. 19

20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65568

PLACE OF DEATH

County of Nezperce
City of Lewiston

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME John Jackson Booth

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): April 9, 1858

7. AGE: Years 70, Months 8, Days, If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Praririation Indiana

PARENTS

10. NAME OF FATHER: Jim Booth
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Praririation Indiana
12. MAIDEN NAME OF MOTHER: Cordelia Tuck
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Praririation Indiana

14. Informant: Mrs. H. Adkins
(Address) Lewiston, Ida

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH 129

16. DATE OF DEATH: 2 (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/16, 1929, to 2/9, 1929
that I last saw him alive on 2/9, 1929
and that death occurred, on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:
Nephritis
with Arterio Ochlerosis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. McElvain, M. D.
2/9, 1929 (Address) Lewiston Wash

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clarkston Wash — Date of Burial: 2/12/2 19

20. Undertaker: H.R.Merchant — Address: Clarkston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65570

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 1st & 18th st.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Hale Lamphier

(a) Residence. No. Genesee Idaho St. Genesee Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 2/ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Dale Lamphier

6. DATE OF BIRTH (month, day and year): Oct 11 1895

7. AGE: Years 33 | Months 4 | Days 11 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Genesee Idaho.

PARENTS

10. NAME OF FATHER: J. M. Vasfurther
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Elizabeth Greser
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Mr J. M. Vasfurther
(Address)

15. Filed ____, 19____ Registrar

MEDICAL CERTIFICATE OF DEATH 148

16. DATE OF DEATH: Feb 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6, 1929, to Feb 22, 1929, that I last saw her alive on Feb 22, 1929, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows: Uremia of pregnancy.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary): Chronic Parenchymatous nephritis (duration) several yrs yrs. mos. ds.

18. Where was disease contracted if not at place of death? Genesee Idaho
Did an operation precede death? yes Date of Feb 7-29
Was there an autopsy? no
What test confirmed diagnosis? Chemical & Microscopic

(Signed) Paul Johnson M. D.
2/32, 1929 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow Idaho.	1929
20. Undertaker	Address
Varsar Mortuary	Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65571

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nettie Gladys Montague.

(a) Residence. No. 317 12th, Street. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of J. M. Montague.

6. DATE OF BIRTH (month, day and year) 3/24/1894.

7. AGE Years	Months	Days	If LESS than 1 day,
34.	11.	----	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tennessee.

PARENTS
10. NAME OF FATHER H. S. Jones.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.
12. MAIDEN NAME OF MOTHER Not known.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant J. M. Montague.
(Address) Lewiston, Idaho.

15. Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February 24th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1929 to Feb 24, 1929
that I last saw her alive on Feb 23, 1929
and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows:
Uremic poisoning of pregnancy
Had Baby stillborn Feb 19-1929
(duration) two weeks
CONTRIBUTORY (Secondary) Organic heart disease
do not know
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Laboratory & clinical

(Signed) Paul D. Johnson, M. D.
2/25/29. 19... (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Lewiston, Idaho.	1/26/29.
20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65572

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. 413 17th, Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Adam C. Spengler.

(a) Residence. No. 413 17th, Street. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 7/18/1858.

7. AGE Years: 70. Months: 7. Days: 7. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Proprietor of Bakery.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Manheim, Germany.

PARENTS

10. NAME OF FATHER: -------- Spengler.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany.

14. Informant S. A. Spengler
(Address) Lewiston, Idaho.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH 90

16. DATE OF DEATH: February 25th, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1929, to Feb 25, 1929
that I last saw him alive on Feb 25, 1929
and that death occurred, on the date stated above, at 9.30 P.m.
The CAUSE OF DEATH* was as follows:

Cardio-Nephritis
(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Albumin & costs in urine

(Signed) E. G. Braddock, M. D.

2/27/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 2/28/29. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Habel.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65573

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No.
Primary Registration District No.
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Mrs Agnes Riggs
(a) Residence. No. 718 - 15th Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo D Riggs

6. DATE OF BIRTH (month, day and year): July 24 1869

7. AGE: Years 59, Months 7, Days 4. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England.

PARENTS
10. NAME OF FATHER: Samuel Wheatcroft
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England.
12. MAIDEN NAME OF MOTHER: Rebecca Eason
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England.

14. Informant: Geo D Riggs
(Address) Lewiston Idaho

15. Filed, 19 Registrar

MEDICAL CERTIFICATE OF DEATH 44

16. DATE OF DEATH: Feb (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1929, to Feb., 1929.
that I last saw her alive on Feb., 1929.
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Gastric Hemorrhage.
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary): Sarcoma of Stomach
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no. Date of
Was there an autopsy? no.
What test confirmed diagnosis? Physical signs
(Signed) Wilfred H Habel, M. D.
, 19 (Address) Lewiston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho. Date of Burial: 3/2 1929

20. Undertaker: Vassar Mortuary Address: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Johnson

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65574

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. 407 Snakeriver Avenue.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ivan Earl DeVault.

(a) Residence. No. 407 Sankeriver Avenue. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Singel.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 7/24/1927.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1.	7.	4.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston, Idaho.
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Samuel DeVault.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Carolyn Leiter.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Oregon.

14. Informant Samuel DeVault.
(Address) Culdesac, Idaho.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 28th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1929 to Feb 28 1929
that I last saw h~~e~~ alive on Feb 28 1929
and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Gastro-intestinal

None (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Paul W. Johnson, M. D.

3/1/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	3/2/29. 19
20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

APR 10

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65525

PLACE OF DEATH

County of Nezperce,
City of Lewiston
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. White Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard Hedler.

(a) Residence. No. Juliaette, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6. DATE OF BIRTH (month, day and year) May 24, 1916

7. AGE	Years	Months	Days	If LESS than 1 day,
	12	10	7	hrs. or min.

8. OCCUPATION OF DECEASED School Boy
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Raymond, Minn.
(State or country)

PARENTS

10. NAME OF FATHER J. M. Hedler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Daisy Kirkman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant J. M. Hedler
(Address) Juliaette, Idaho.

15. Filed Apr 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH 101-a

16. DATE OF DEATH
March 31st, 1929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from
3-24, 1929, to 3-31, 1929
that I last saw him alive on 3-31, 1929
and that death occurred, on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Mitral regurgetation
(duration) ? yrs. mos. ds.

18. Where was disease contracted if not at place of death? Julietta Ida.
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. F. McMahan, M. D.
4-2-, 1929 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fix Ridge	Apr. 3, 1929 19
20. Undertaker	**Address**
Brower - Wann CO.	Lewiston, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65576

PLACE OF DEATH
County of Oneida
City of Malad
R. F. D. #1

Registration District No. 26
Primary Registration District No. 2069
Local Registrar's No. 3
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jane Mason Hughes

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Jabisin Hughes

6. DATE OF BIRTH (month, day and year) Jan. 22 - 1859

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	1	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wales

10. NAME OF FATHER Thomas Mason

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales.

12. MAIDEN NAME OF MOTHER Elizabeth Mason

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales.

14. Informant T. Hughes Jr.
(Address) R.F.D. #1 Malad Ida

15. Filed 3/31, 1929 J. M. Harris Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 11 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1929, to March 11, 1929
that I last saw her alive on March 10, 1929
and that death occurred, on the date stated above, at 4:30 a.m.
The CAUSE OF DEATH* was as follows:
Myocarditis general debility
(duration) ? yrs. mos. ds.
CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? same
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) W. W. Meloy, M. D.
3/11, 1929 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pleasantview Ida	Mar 13 1929
20. Undertaker	Address
J. Guy Duncan	Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 3 1929

PLACE OF DEATH

County of Oneida

City of Malad

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 26

Primary Registration District No. 2069

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65577

Local Registrar's No. 4

2. FULL NAME Anna Price Davis

(a) Residence. No. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Owen J. Davis

6. DATE OF BIRTH (month, day and year): Apr. 26 1877

7. AGE: Years: 51 | Months: 10 | Days: 14 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Tamania Ida.

PARENTS

10. NAME OF FATHER: Daniel E. Price

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Mary Jenkins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14. Informant: Owen V. Davis

(Address): Grandford Ida

15. Filed 3/31, 1929 J. M. Kerrod Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. 12 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1925, to March 12, 1929 that I last saw her alive on March 10, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Mitral regurgitation

Mitral stenosis

2 years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) [illegible], M. D.

12/14, 1929 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Tamania Ida — Date of Burial: Mar 16 1929

20. Undertaker: J. Guy Benson — Address: Malad Ida

RECEIVED APR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65578

PLACE OF DEATH
County of Owhyee
City of Oreana

Registration District No. 74
Primary Registration District No. 2157

Local Registrar's No. 41

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anne Catharine Bailey

(a) Residence. No. 1 Mile South of Oreana Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 19 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	2	12	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Richard Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Rachel Seacord
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Jesse C. Bailey
(Address) Oreana Idaho

15. Filed Apr. 3, 1929 W J Eisenbeck Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 31st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on March 31, 1929, to ....., 19.....
that I last saw her alive on March 31, 1929
and that death occurred, on the date stated above, at 8:30 P. m.
The CAUSE OF DEATH* was as follows:

Enteritis and diarrhea

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) senility

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Wm J Eisenbeck, M. D.
Apr. 3, 1929 (Address) Grand View

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemitery — Date of Burial: Apr 3 1929
20. Undertaker: Summers & Krebs — Address: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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RECEIVED MAR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65579

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 6

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ivin Kizzier
(a) Residence. No. 117 Tenth St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widower.

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Eliza Ann Gobble.

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84	11	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: retired farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ind.

PARENTS
10. NAME OF FATHER: Ivin Kizzier
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ind.
12. MAIDEN NAME OF MOTHER: unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown.

14. Informant: Goldie Kizzier
(Address) Payette Idaho

15. Filed Feb. 10, 1929. J. C. Woodward, Registrar

MEDICAL CERTIFICATE OF DEATH 99-6

16. DATE OF DEATH: Feb. (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 10, 1929, to Feb. 9, 1929
that I last saw him alive on Feb. 9, 1929
and that death occurred, on the date stated above, at 10:00 a. m.
The CAUSE OF DEATH* was as follows:
Chronic Bronchitis
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical symptoms
(Signed) O. H. Avey, M. D.
Feb 26, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Payette. Ida. Date of Burial: Feb 10

20. Undertaker: Glenn C Landon. Address: Payette. Ida.

RECEIVED MAR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65580

PLACE OF DEATH

County of Payette
City of Fruitland

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 7

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fredric James Stirm

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	W.	single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	3.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: baby.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Fruitland

PARENTS

10. NAME OF FATHER: W. E. Stirm.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Payette. Ida.
12. MAIDEN NAME OF MOTHER: Emma J. Bosch.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Payette. Ida.

14. Informant: Mrs E. Stirm
(Address)

15. Filed Feb 17, 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 16, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1929, to Feb 16, 1929, that I last saw him alive on Feb 16, 1929, and that death occurred, on the date stated above, at 11.00 a m.

The CAUSE OF DEATH was as follows:
Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. C. Woodward, M. D.
Feb 16, 1929 (Address) Payette. Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette. Ida.	Feb 17 1929
20. Undertaker	Address
Glenn C Sundin.	Payette. Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65582

PLACE OF DEATH

County of Payette

City of Payette

Registration District No. 4

Primary Registration District No. 1008

(No. .....)

Local Registrar's No. 9

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME George Wright

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Racheal Wright Deceased

6 DATE OF BIRTH (month, day and year) Nov 26 1841

7 AGE Years 87 Months 3 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Wm G. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER X X

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Jennie Wilson

(Address) Payette Ida

15 Filed Feb 28, 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH 90

16 DATE OF DEATH Feb (Month) 25 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 1909, to Feb 23, 1929, that I last saw him alive on Feb 23, 1929, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

..... (duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J R Woodward M. D.

2/27, 1929 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Payette Ida

Date of Burial Feb 27 1929

20. Undertaker J. H. Adair

Address Peterson Furn Co Payette Ida

RECEIVED APR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65583

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Power — Registration District No. 23

City of American Falls, Idaho — Primary Registration District No. 2072

(No.) — Local Registrar's No. 6

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Julia A. Lee

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of C.F. Lee

6 DATE OF BIRTH (month, day and year) Dec 12 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind

PARENTS

10 NAME OF FATHER Frances M. Kieth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Martha McClain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mich

14 Informant Robert E. Lee
(Address) American Falls, Idaho

15 Filed 3-26, 1929 Genevieve Noth Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
March 25th 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended/deceased from Jan 30, 1929, to Mch 25th, 1929, that I last saw her alive on Mch 24th, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W H Logan, M. D.

March 25th 1929 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: I.O.O.F. Cemetery — Date of Burial: Mar 26 1929

20. Undertaker: Ayr Davis — Address: American Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65584

PLACE OF DEATH

County of Power

City of American Falls

Registration District No.

Primary Registration District No.

Local Registrar's No. 1

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank J. Moore

(a) Residence. No. 4 miles north of Roy, Idaho St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Ora Moore

6. DATE OF BIRTH (month, day and year) Dec 18th 1885

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	0	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS

10. NAME OF FATHER John Moore

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant A W Davis

(Address) American Falls, Idaho

15. Filed 1-15-, 1929 Geneva Nott Registrar

MEDICAL CERTIFICATE OF DEATH 19

16. DATE OF DEATH January 13th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

From a gun shot wound, by a rifle in the hands of his wife Ora Moore.

Coroners Verdict, justifible

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Homicide

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A W Davis Coroner

, 19 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F. cemetery	1/16/29 19

20. Undertaker A W Davis Am Address Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65585

PLACE OF DEATH
County of Power
City of Am Falls

Registration District No. 25
Primary Registration District No. 2072
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

2. FULL NAME Marintha A. Savage

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of [illegible]

6. DATE OF BIRTH (month, day and year) Jan 17 1850

7. AGE Years 79 Months 1 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) England.

PARENTS
10. NAME OF FATHER Joseph Wright
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Martha Rippon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Mrs H. E. Field.
(Address)

15. Filed 3/5, 1929 Genevieve Roth Registrar

MEDICAL CERTIFICATE OF DEATH 49

16. DATE OF DEATH Mch (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1928, to Mch 2, 1929
that I last saw her alive on Mch 2, 1929
and that death occurred, on the date stated above, at 8.40 a m.
The CAUSE OF DEATH* was as follows:
Carcinoma of carcinum.
..... (duration) 1 yrs. about ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? autopsy
(Signed) C. F. Schultz, M. D.
3/2, 1929 (Address) Am. Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal [illegible] Date of Burial 19

20. Undertaker A. W. Davis Address Am Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65586

PLACE OF DEATH
County of Power
City of Am Falls
Registration District No. 25
Primary Registration District No. 2012
(No.)
Local Registrar's No. 4

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Josephine M. Bartlett

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of C. G. Bartlett

6 DATE OF BIRTH (month, day and year) June 1 1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	8	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10 NAME OF FATHER O. Y. Alvord.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Melissa Ann Talbott.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant C. G. Bartlett
(Address) Rockland, Ida.

15 Filed 2-18, 1929 Geneviève Nolt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mch (Month) 9th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mch 9, 1929, to Mch 14, 1929, that I last saw her alive on Mch 14, 1929, and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) V. G. Logan, M. D.
3-16, 1929 (Address) Amsterdam

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Rockland	Mch. 18 1929
20. Undertaker	Address
A. W. Davies	Am. Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 4 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65587

County of Power — Registration District No. 25

City of American Falls, Idaho — Primary Registration District No. 2079

Local Registrar's No. 5

(No. Bethany Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Frank Einberger

(a) Residence. No. ____ St. ____

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan 21 1844

7 AGE

Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
85	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Louis Einberger jr

(Address) American Falls, Idaho

15 Filed 3-26, 1929 Genevieve Nott Registrar

MEDICAL CERTIFICATE OF DEATH 129

16 DATE OF DEATH March 25 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1929, to March 25, 1929, that I last saw h[illegible] alive on March 25, 1929, and that death occurred, on the date stated above, at 12:50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Influenza & uremia

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) C. F. Jones M. D.

March 26 1929 (Address) Am. Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Pocatello, Ida	Mar 27/29

20. Undertaker A W Davis — Address American Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 15 1929

PLACE OF DEATH

County of Shoshone

City of Wallace

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65588

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 11

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mr Mark Lehta

(a) Residence. No. Stanley Hotel St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): not Known

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: not Known

6. DATE OF BIRTH (month, day and year)

7. AGE: About 50 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Not Known

PARENTS

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: [illegible] Benr

(Address) Wallace Idaho

15. Filed Feb 6, 1929. J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

11-B

16. DATE OF DEATH: Feb (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1928 to Feb 5, 1929

that I last saw him alive on Feb 5, 1929

and that death occurred, on the date stated above at 7:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis acute
Mitral Regurgitation
Several
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds. 15-20

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Dr. [illegible], M. D.

2/10, 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Buckley Wash. Date of Burial: Shipped Feb 6 1929

20. Undertaker: J. A. Bower Ward Vend Co. Address: Wallace Idaho

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65589

PLACE OF DEATH
County of Shoshone — Registration District No. 20
City of Wallace — Primary Registration District No. 20 11 — Local Registrar's No. 12
(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Louis Larson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 20 - 1855

7 AGE — Years: 74 — Months: 7 — Days: 12 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norway

PARENTS
10 NAME OF FATHER: Louis Larson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Norway
12 MAIDEN NAME OF MOTHER: —
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Norway

14 Informant: Edgar Larson
(Address): 2331 N 53rd Seattle Wash

15 Filed Feb 8, 1929 — L. L. Quigley, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: February (Month) 5th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Feby 5, 1929, that I last saw h[illegible] alive on Feby 4, 1929, and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis 2 yrs
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Organic debility
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) James L Dean, M. D.
2/8/1929 19 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Wallace Idaho — Date of Burial: Feb 8 1929
20. Undertaker: Jos Bowen Ward Undertaking Co. — Address: Wallace Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65590

PLACE OF DEATH

County of Shoshone

City of Burke

Registration District No. 70

Primary Registration District No. 1011

(No. .....)

Local Registrar's No. 13

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME John T. McGann

(a) Residence. No. Burke, Idaho St. Burke Idaho.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

66

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: Years: About 65 | Months: | Days: | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Miner.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Patrick McGann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Not Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: John Murphy

(Address): Wallace Idaho.

15 Filed Feb 4, 1929 T. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb 7 (Month) (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....,

that I last saw my alive on Feb 7, 1929

and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic
Mitral regurgitation
Dropped dead

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Alcoholism & heart lesion

(duration) Several yrs. mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Mowery Corona M.D.

Feb 7, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Wallace Idaho

Date of Burial: 2/9/29 19

20. Undertaker: J. A. Bower Ward Undertaking Co.

Address: Wallace Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65591

PLACE OF DEATH — CERTIFICATE OF DEATH

County of Shoshone — Registration District No. 70

City of Wallace — Primary Registration District No. 10 11

Local Registrar's No. 14

(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Norman G. Brown

(a) Residence. No. 528 Pine Street St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec 10.1866

7 AGE Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
62	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk Clothing

(b) General nature of industry, business, or establishment in which employed (or employer) O.K. Clothier

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Dorthy Micheals

(Address) Oakland Calif.

15 Filed Feb 13, 1929 F. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH 10-a

16 DATE OF DEATH
Feb. (Month) 9 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feby 6, 1929, to Feby 9, 1929, that I last saw him alive on Feby 8, 1929, and that death occurred, on the date stated above, at 8-a m.

The CAUSE OF DEATH* was as follows:

Double lobar Pneumonia

(duration) ____ yrs. ____ mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Shaw M. D.

2/11, 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wash	Feb. 13 1929
20. Undertaker Worstell Co	Address Wallace

J. P. Shaughnessy

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65592

PLACE OF DEATH

County of Shoshone
City of Mullan

CERTIFICATE OF DEATH

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 15

2. FULL NAME Charles C Sorenson

(a) Residence. No. 535 Hunter Ave. St. Mullan, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Divorced

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Divorced

6 DATE OF BIRTH (month, day and year) Dec 12 - 1856.

7 AGE Years 72 Months 2 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Retired.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS
10 NAME OF FATHER Not Known.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known
12 MAIDEN NAME OF MOTHER Not Known.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known.

14 Informant Mrs M. F. La Gore
(Address) Mullan, Idaho

15 Filed Feb 20, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH 91-6

16 DATE OF DEATH Feb (Month) 16 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct - 11, 1928, to Feb. 16, 1929, that I last saw him alive on Feb - 16, 1929, and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:
Vascular Heart disease
(duration) Several yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) several yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Fred V. Griffith, M. D.
Feb - 16, 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Burlington, Wash. Date of Burial Feb 20 1929

20. Undertaker J. A. Bever Ward Und. Co. Address Wallace, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65593

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Shoshone
City of Mullan

Registration District No. 20
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 16

2. FULL NAME Peggy May Murray
(a) Residence. No. 229 Pine St. St. Mullan, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Girl
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 13 1922

7 AGE: 6 Years, 7 Months, 4 Days. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wallace, Ida

PARENTS
10 NAME OF FATHER: Henry Murray
11 BIRTHPLACE OF FATHER (city or town) (State or country): Missouri
12 MAIDEN NAME OF MOTHER: Molly McKinney
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Darby - Mont

14 Informant: Molly McKinney
(Address) Mullan, Ida.

15 Filed Feb 22, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH 18

16 DATE OF DEATH: Feb (Month) 17 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 4:35 PM Feb 17, 1929, to 5:45 PM Feb 17 1929, that I last saw her alive on Feb 17, 1929, and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:
Status Epilepticus
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Exertion (over exertion)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) F. W. Rolf, M. D.
Feb 18, 1929 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Darby Montana Wallace Ida — Date of Burial: Shipped Feb 22 1929

20. Undertaker: Joe Bever for Ward's Undertaking Co — Address: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED MAR 15 1929

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65594

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)
Local Registrar's No. 17

2. FULL NAME Josie S. Paull

(a) Residence No. Eagle Blk. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Roger Paull

6 DATE OF BIRTH (month, day and year) Nov 5 - 1905

7 AGE Years 23 Months 3 Days 13 If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Davenport Wash.

PARENTS
10 NAME OF FATHER Ed Sutherlin
11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas
12 MAIDEN NAME OF MOTHER Arlie Hoffman
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Roger Paull
(Address) Wallace, Idaho

15 Filed Feb 22, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH 88-6

16 DATE OF DEATH Feb (Month) 18 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ___, 19___, to Feb 18, 19___, that I last saw her alive on Feb 18, 19___, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows: Suddenly collapsed in bed apparently heart failure
(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Mental Regurgitation Myocarditis Severe
(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H C Mowry Coroner
Feb 19, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Davenport Wash. Date of Burial Feb 22 1929

20. Undertaker J. A. Bever Ward Undertaking Co. Address Wallace Ida

RECEIVED MAR 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65595

PLACE OF DEATH

County of Shoshone
City of Wallace

CERTIFICATE OF DEATH

Registration District No. 70
Primary Registration District No. 1011
(No. 103 Bank Street)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 18

2. FULL NAME David Harrison Roberts

(a) Residence. No. 103 Bank Street St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug 7 1927

7 AGE: Years 1 | Months 6 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) San Diego California

PARENTS
10 NAME OF FATHER Harold C Roberts
11 BIRTHPLACE OF FATHER (city or town) (State or country) New York
12 MAIDEN NAME OF MOTHER Faith Newton
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wisconsin

14 Informant Mrs C.W. Newton
(Address) Wallace Idaho

15 Filed [illegible], 19[illegible] [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH 100-a

16 DATE OF DEATH
Feb (Month) 20 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 13 1929, to Feb 20, 1929, that I last saw him alive on Feb 20, 1929, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia
(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physicians
(Signed) [illegible] M. D.
2-21-29, 19..... (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: United Cemetery
Date of Burial: 2/22/29

20. Undertaker Worstell Co
J. P. Shaughnessy
Address: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19. RECEIVED APR 6

CERTIFICATE OF DEATH

State of Idaho
BOARD of HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No. 2201
File No. 65596
Registered No. 17

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Earl Lear
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept 8 1904 (Month) (Day) (Year)

7. AGE: 19 Yrs. 6 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Interne
(b) General nature of industry, business or establishment in which employed (or employer): Smelter

9. BIRTHPLACE (State or Country): Houston Mo.

10. NAME OF FATHER: Geo E. Lear

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Florence May Purfit

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. Bridwell & Lear
(Address) Kellogg Idaho

15. Filed Mar 30 1929 Mrs. Helen M. Britt Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 10, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Brain abscess following an orbital abscess

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. A. Kennett M. D.
19..... (Address) Kellogg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greenwood Cemetery — DATE OF BURIAL: March 13 1924

20. UNDERTAKER: M. E. Saunders — ADDRESS: Kellogg Idaho

MARGIN FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M—7-19

RECEIVED APR 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone

City of Kellogg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123

Primary Registration District No. 2201

(No. ..... St.)

File No. 65597

Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leonard Gilbert Hart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept (Month) 21st (Day) 1855 (Year)

7. AGE: 68 Yrs. 3 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Hoisting Engineer

(b) General nature of industry, business or establishment in which employed (or employer): Mines

9. BIRTHPLACE (State or Country): Wisconson ~~Waukesha~~ Waukesha

10. NAME OF FATHER: Charles Hart

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Hanna Hart

13. BIRTHPLACE OF MOTHER (State or Country): dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Kate Hart

(Address) Kellogg Idaho

15. Filed Mar. 30 1929 Mrs. Helen McBride Local Registrar

MEDICAL CERTIFICATE OF DEATH 88 B

16. DATE OF DEATH: Jan (Month) 17 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Carbuncle

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo J Kennett M. D.

..... 19..... (Address) Kellogg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg

DATE OF BURIAL: Jan 20 1924

20. UNDERTAKER: M. C. Thornhill

ADDRESS: Kellogg Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65598

PLACE OF DEATH

County of Shoshone

City of Kellogg

Registration District No. 123

Primary Registration District No. 3201

Local Registrar's No. 9

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Thomas

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	Sing[illegible]

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 3, 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg, Idaho

PARENTS

10. NAME OF FATHER Robert Thomas

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colorado

12. MAIDEN NAME OF MOTHER Anna Italyng

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant Robt. Thomas.
(Address) 132 N Mullan - Kellogg Ida

15. Filed Mar. 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH 159-B

16. DATE OF DEATH Feb 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/3/, 1929, to 2/18/, 1929
that I last saw h[illegible] alive on 2/17/, 1929
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:

Failure of Foramen Ovale to Close.

(duration) Since Birth yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phys. Exam.

(Signed) R. S. MacDougall, M. D.
2/20/, 1929 (Address) Kellogg, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg. Idaho	Feb 19 1929
20. Undertaker	Address
M. E. Thornhill	Kellogg, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65599

Local Registrar's No. 10

PLACE OF DEATH

County of Shoshone
City of Kellogg.
Registration District No. 123
Primary Registration District No. 220
(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Edna Breeds LeRoy

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of W. W. LeRoy

6 DATE OF BIRTH (month, day and year) Aug 9 - 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	7		

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Champaign Ill

PARENTS

10 NAME OF FATHER C. F. Singhusen
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Renfrow.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Champaign Ill

14 Informant Mrs. E. Spurlock
(Address) Eureka Springs Ark.

15 Filed Mar 30, 1929 Mrs. Helen M. Bird Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 3 (Month) 9 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1928 to March 9th 1929, that I last saw her alive on March 6th 1929, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver.
(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of Dec 26th 1928
Was there an autopsy? Yes.
What test confirmed diagnosis? Autopsy
(Signed) H. C. Liddell, M. D.
3/10, 1929. (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wash	Mar 12 1929

20. Undertaker R. F. Faust — Address Kellogg Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65600

County of Kootenai
City of Dudley

Registration District No. 123
Primary Registration District No. 2201

Local Registrar's No. 11

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lydia Susan Byrne

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of L. D. Byrne

6. DATE OF BIRTH (month, day and year) Nov. 13 th 1849

7. AGE	Years	Months	Days	If LESS than 1 day,
	80	4		hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lawrenceburg Ind

PARENTS

10. NAME OF FATHER William Ford

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER Johanna Lord

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) State Maine

14. Informant Marcellus Byrne
(Address) Cataldo Ida Jr. Route 1

15. Filed Mar. 30, 1929 Mrs. Helen M. Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1928, to Mar. 12, 1929, that I last saw her alive on Mar. 12, 1929, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:
hypostatic pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) cerebral hemorrhage
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. F. Field, M. D.
Mar. 14, 1929 (Address) Coeur d'Alene, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rose Lake	3/16 1929
20. Undertaker R. L. Stout	Address Kellogg Ida

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65602

PLACE OF DEATH
County of Shoshone
City of Kellogg
Registration District No. 123
Primary Registration District No. 2201
(No. .....)
Local Registrar's No. 13
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Jacob Saari

(a) Residence. No. Main St St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mary Saari

6 DATE OF BIRTH (month, day and year) Jan 31 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	1	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Finland

PARENTS
10 NAME OF FATHER John Saari
11 BIRTHPLACE OF FATHER (city or town) (State or country) Finland
12 MAIDEN NAME OF MOTHER ?
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Finland

14 Informant Mrs. Mary Saari
(Address) Kellogg, Idaho

15 Filed Mar. 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3 (Month) 18 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1929, to March 19, 1929, that I last saw him alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Septicaemia,
..... (duration) 9 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Chronic arthritis
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? General examination
(Signed) W. L. Lindsay M. D.
3/19, 1929 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Kingston Ida	March 1929
20. Undertaker R. L. Stout	Address Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65603

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14

2. FULL NAME Thomas Milligan Rodgers

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Rodgers

6. DATE OF BIRTH (month, day and year): March 29, 1853

7. AGE: Years 75, Months 11, Days 29. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS
10. NAME OF FATHER: John Rodgers
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penna
12. MAIDEN NAME OF MOTHER: Sarah Amick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penna

14. Informant: Maxine Phillips
(Address): Kellogg, Idaho

15. Filed Mar. 30, 1929. Mrs. Helen McBride, Registrar

MEDICAL CERTIFICATE OF DEATH

43 MacDougall

16. DATE OF DEATH: March (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan -, 1924, to March, 1929
that I last saw him alive on 3/20/, 1929.
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Carcinoma - rt Thorax
..... (duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary): Carcinoma rt Hand.
..... (duration) 6 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) A. S. MacDougall, M. D.
3/30/1929 (Address) Kellogg, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg Idaho — Date of Burial: Mch 31 1929

20. Undertaker: M. C. Thornhill — Address: Kellogg, Idaho

Exact statement of OCCUPATION is very important. See instruction on back of certificate. Should state CAUSE OF DEATH in plain terms, so that it may be properly classified.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65604

PLACE OF DEATH
County of Shoshone
City of Hypotheck Mine

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15

2. FULL NAME Alvin Devereaux

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 9, 1885

7. AGE: Years 43, Months 7, Days 19. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Rust, Illinois

PARENTS

10. NAME OF FATHER: Donald Devereaux
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ~~Mary~~ ~~Arnold~~
12. MAIDEN NAME OF MOTHER: Mary Arnold
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Mrs. E. S. Tucker
(Address) Kellogg Ida

15. Filed Mar. 30, 1929. Mrs. Helen McBride, Registrar

MEDICAL CERTIFICATE OF DEATH

90

16. DATE OF DEATH: March (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1924, to 3/28/, 1929.
that I last saw him alive on 3/25/, 1929.
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Valvular Heart Lesions.

..... (duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diseased Tonsils.
Removed 10 yrs ago. (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? no.
What test confirmed diagnosis?
(Signed) A. S. MacDougall, M. D.
3/30/, 1929 (Address) Kellogg, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kingston Idaho. Date of Burial: Mch 30 1929

20. Undertaker: M. C. Thornhill. Address: Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65607

PLACE OF DEATH
County of Teton
City of Victor

Registration District No. 77
Primary Registration District No. 2176
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Victor Curtis Brown

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) March 17th 1929

7. AGE Years	Months	Days	If LESS than 1 day, 9 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Victor
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Wm Brown
11. BIRTHPLACE OF FATHER (city or town) Chester
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Veda May Atkinson
13. BIRTHPLACE OF MOTHER (city or town) Woodruff
(State or Country) Utah

14. Informant Mrs. O. B. Curtis
(Address) Victor Idaho

15. Filed 3-20-, 1928 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH 16 a

16. DATE OF DEATH
March (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
March 17, 1929, to Mar 17, 1929
that I last saw him alive on March 17, 1929
and that death occurred, on the date stated above, at 4 30 P m.
The CAUSE OF DEATH* was as follows:
Premature Born
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) Mrs O B Curtis, midwife
3-18-, 1929 (Address) Victor Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Victor Ida	Mar 17 1929
20. Undertaker	Address
—	—

RECEIVED APR 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65608

PLACE OF DEATH

County of Teton
City of Driggs
Registration District No. 77
Primary Registration District No. 2176
Local Registrar's No. 6
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richins.

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 3rd 1929

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Driggs, Idaho.

PARENTS

10. NAME OF FATHER Roy Richins.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pleasant Grove Utah
12. MAIDEN NAME OF MOTHER Barbara Van Fleet
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mt View Wyoming

14. Informant Roy Richins
(Address) Driggs, Idaho.

15. Filed 3-10-, 1929 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 4- 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from (Mar 3- 1929, to March 4- 1929
that I last saw her alive on Mar 4- 1929
and that death occurred, on the date stated above, at 4 A. m.
The CAUSE OF DEATH* was as follows:
Premature

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G. C. Parkinson, M. D.
3-4-, 1929 (Address) Driggs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Driggs, Ida	3-5- 1929
20. Undertaker	Address
—	—

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65609

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME John T. Hallett

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 22 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	67	11	10.	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer) Road Construction
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah.

PARENTS

10. NAME OF FATHER Thatcher C. Hallett.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Irmina Hayden.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant .....
(Address) .....

15. Filed Mar. 8, 1929 J. W. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH 90

16. DATE OF DEATH Mar. (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency
Follow Paralytic Stroke
Duration of long duration
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) died unattended.
No question
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis .....
(Signed) J. E. Drake Coroner M. D.
Mar 7, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl Ida.	Mar. 5 1929
20. Undertaker L. D. Johnson	Address Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65610

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2027
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myra Victoria Estes

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fred Estes

6. DATE OF BIRTH (month, day and year) Jan. 6

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	1	16.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rock Island Ill.

PARENTS

10. NAME OF FATHER Swan Quist.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden.
12. MAIDEN NAME OF MOTHER Anna Johnson.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden.

14. Informant Mrs. A. H. Nelson
(Address) Buhl, Ida

15. Filed Mar. 8, 1929 J. W. Murphey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1928, to Mar. 7, 1929
that I last saw her alive on Mar. 6, 1929
and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:
Pulmonary Edema secondary to recurrent Cancer of breast.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of breast.
(duration) 3. yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 1927-1928.
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) C. E. Berry, M. D.
Mar. 7, 1929 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl Ida.	Mar. 10 1929
20. Undertaker L. L. Johnson	Address Buhl Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65611

PLACE OF DEATH
County of Twin Falls.
City of Buhl.

Registration District No. 39
Primary Registration District No. 2087
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Loyd Norman Kendrick.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) —

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 16. 1928.

7. AGE Years | Months 2 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buhl Idaho

PARENTS
10. NAME OF FATHER Otis Kendrick.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Mabel Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Mrs Mary Brown
(Address)

15. Filed Mar. 1A, 1929. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH 113

16. DATE OF DEATH Mar. (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 3, 1929, to Mar. 13, 1929
that I last saw him alive on Mar. 12, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows: Ileio Colitis.

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Symptoms.
(Signed) J. H. Murphy, M. D.
Mar. 1A, 1929 (Address) Buhl

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Ida. | Date of Burial Mar. 15 1929

20. Undertaker Neville D. Rugg. | Address Buhl Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65612

PLACE OF DEATH
County of Twin Falls
City of Buhl
Registration District No. 39
Primary Registration District No. 2087
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Ringuet

(a) Residence. No. Buhl ~~Scattered~~ Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Margaret Ringuet

6. DATE OF BIRTH (month, day and year) Nov. 13 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	4	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pa.

PARENTS
10. NAME OF FATHER J. R. Ringuet
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Barth Haggewald.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Margaret C. Ringuet
(Address) Buhl Ida.

15. Filed 3-14, 1929. J. T. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH 129

16. DATE OF DEATH Mar. (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar., 1926, to Mar. 14, 1929
that I last saw him alive on Mar 7, 1929
and that death occurred, on the date stated above, at 8 a.m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis.
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory.
(Signed) J. T. Murphy, M. D.
Mar. 14, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl Cemetary	Mar. 17 1929
20. Undertaker	Address
Wells & Rugg.	Buhl Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65614

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1095
Local Registrar's No.
(No. County Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucille Helen Gentry
(a) Residence. No. 1335 Addison ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) 10-6-1912
7. AGE 16 Years 6 Months 24 Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Hansen Ida.

PARENTS
10. NAME OF FATHER C. L. Gentry
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark.
12. MAIDEN NAME OF MOTHER Marry Walker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ark.

14. Informant C L Gentry
(Address) 1335 Addison Ave
15. Filed 4-10, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH 24

16. DATE OF DEATH Apr (Month) 1st (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar. 30, 1929, to Apr 1st, 1929
that I last saw her alive on Apr 1st, 1929
and that death occurred, on the date stated above, at 1:30 pm
The CAUSE OF DEATH* was as follows: Epidemic Cerebro Spinal Meningitis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) 0
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Confirmed from Spinal Cerebro Spinal Meningitis
(Signed) [illegible] M. D.
4-7, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: Apr 4 1929
20. Undertaker: P. J. Grossman
Address: [illegible]

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65615

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No.
Primary Registration District No. 2 35
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ella Wanda Hines

(a) Residence. No. Filer St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wirkola

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7 months	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER R. S. Hines
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark
12. MAIDEN NAME OF MOTHER Willie Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ark

14. Informant R. S. Hines
(Address) Filer.

15. Filed Apr 12, 1929. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH 162

16. DATE OF DEATH May 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased, from 1:30 PM 3/27, 1929, to 3 o'clock 3/27 1929
that I last saw her alive on 3/27, 1929
and that death occurred, on the date stated above, at 6:30 P m.
The CAUSE OF DEATH* was as follows:

Pulmonary and cardiac insufficiency
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) JE Wyly D.C.
Apr 3, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Filer Cemetary	May 28 1929

20. Undertaker F E Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65616

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No.

(No. Twin Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph A Stewart

(a) Residence. No. Burke St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 5 1922

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
6	11	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER D F Stewart

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Okla

12. MAIDEN NAME OF MOTHER Flocy Phillips

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind

14. Informant D F Stewart

(Address) Burke

15. Filed 4-10, 1929 H. M. Lewis Registrar

MEDICAL CERTIFICATE OF DEATH

Hallett 8.30

16. DATE OF DEATH Apr 1 (24) 1929

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14, 1929, to apr 1, 1929

that I last saw h[im] alive on apr 1, 1929

and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebro Spinal Meningitis

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? Home -

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Lab. findings

(Signed) George C Bailey, M. D.

apl 1, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Cemetary	Apl 3 1929

20. Undertaker F C Drake

Address Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65617

PLACE OF DEATH
County of Twin Falls.
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1095
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Elizabeth Wild
(a) Residence. No. Rural Apt. D. Twin Falls. Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. A. Wild

6. DATE OF BIRTH (month, day and year) Dec 20 - 1862

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	3	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER Thomas Chandler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Catharine Laney
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant J. A. Wild
(Address) Rural Apt D Twin Falls Ida

15. Filed 4-10, 1929 H. N. Keeta Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16, 1928, to April 1st 1929
that I last saw her alive on April 1st 1929
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:

Bronchitis Chr. Purulent Non H.
(duration) 15 yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis Chronic
(duration) 12 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Nebraska
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory & X ray.
(Signed) Duncan L. Hawkins M. D.
4-1-29, 19 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Wilber Nebr	
20. Undertaker White Mortuary	Address Twin Falls Idaho

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65618

PLACE OF DEATH
County Twin Falls
City of Kimberly
Registration District No. 37
Primary Registration District No. 204
Local Registrar's No. 56
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bertha M Drayden

(a) Residence. No. Kimberly St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of C S Drayden

6. DATE OF BIRTH (month, day and year) Dec 26 / 1882

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	2	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER E E Howard

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo

12. MAIDEN NAME OF MOTHER Maggie Hedrick

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill

14. Informant C S Drayden
(Address) Kimberly

15. Filed 4-3, 19 29 Ewa M Kirk Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1928, to Mch 18, 1929
that I last saw h alive on March 8, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease &
Chronic nephritis.
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Filer Idaho R F D
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H W Orlan, M. D.
March 25, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Filer Cemetery	March 24 1929

20. Undertaker J E Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65619

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 55

2. FULL NAME Adison T Greene
(a) Residence. No. 314 Quincy St St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosy B Green

6. DATE OF BIRTH (month, day and year): March [illegible]

7. AGE: 70 Years | Months | Days: 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: John Y Green
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Nat Known ~~Rosy Roots~~
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Nat Known

14. Informant: J. W. Greene
(Address): Rogerson Ida

15. Filed 4-10 1929. Dr. H. N. Leete Registrar

MEDICAL CERTIFICATE OF DEATH

44

16. DATE OF DEATH: March (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21, 1928, to March 26, 1929 that I last saw him alive on March 25, 1929 and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma Gastric
(duration) 1 yrs. 6 mos. ✓ ds.

CONTRIBUTORY (Secondary) Nephritis Chronic-Hypertrop. Prostate (duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) Duncan L Alexander, M. D.
3/27/29, 19 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls | Date of Burial: Mar. 29 1929

20. Undertaker: F. E. Drake | Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65620

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2025
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 54

2. FULL NAME J L Des Ruisseaux
(a) Residence. No. Farm 3 Mi West St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept 15/1861

7. AGE: Years 67, Months 6, Days 4. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS
10. NAME OF FATHER: L. Des Ruisseaux
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ark.
12. MAIDEN NAME OF MOTHER: Elizabeth
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pertuis Ark.

14. Informant: Mrs. Des Ruisseaux
(Address): Twin Falls

15. Filed 4-10, 1929 H. N. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 19 (Day) 1929 (Year) 10. 14a

17. I HEREBY CERTIFY, That I attended deceased from April, 1928, to March 19, 1929
that I last saw him alive on March 19, 1929
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage
(duration) yrs. mos. 3 hrs ds.
CONTRIBUTORY (Secondary): Arterial Hypertension
(duration) Two yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? B. Pressure
(Signed) John F. Laughlin M. D.
3-22 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery — Date of Burial: Mar 23 1929

20. Undertaker: F E Drake — Address: Twin Falls

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65621

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No. 53

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

(No. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louis Travis Deaverton

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 17 1912

7. AGE	Years	Months	Days	If LESS than 1 day,
	16	10	9	hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Student

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER L. G. Deaverton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Nola Ponkel

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant L. G. Deaverton

(Address) Buhl R. 1

15. Filed 4-10, 1929 H. N. Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22, 1929, to Feb. 26, 1929

that I last saw him alive on Feb 26, 1929

and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebro Spinal Meningitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) A. G. Deaverton, M. D.

Feb 26, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Filer Cemetary	Mar. 1 1929

20. Undertaker H. C. Drake | Address Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65622

Local Registrar's No. 52

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Drake

(a) Residence. No. Hospital St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years — Months — Days — If LESS than 1 day, 3 hours hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Loren G. Drake

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Maeal Beemer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Loren G Drake

(Address) Filer

15. Filed 4-10-, 1929 H N Lees Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 28 1929 3 o'clock

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1929, to Feb. 28, 1929, that I last saw him alive on Feb. 28, 1929, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Premature.

(duration) yrs. 3 Hours.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) T. A. Wright Jr., M. D.

Feb 29, 1929 (Address) Filer Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer Cemetary — Date of Burial: Mar. 1 1929

20. Undertaker: F E Drake — Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Dwight

DO NOT WRITE IN THIS SPACE
State File No. 65623

PLACE OF DEATH
County of Twin Falls
City of Filer Ida

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 51

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Geraldine Waterhouse

(a) Residence. No. Filer Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe Mal
4. COLOR OR RACE whil
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 12 - 1928

7. AGE — Years 1 Months 1 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Albert Waterhouse
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Paulin Ma Caw
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Mrs M J Ma Caw
(Address)

15. Filed 4-10-, 1929 H N Lutz Registrar

MEDICAL CERTIFICATE OF DEATH

6V

16. DATE OF DEATH Mar. 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 16, 1929, to Mar. 16, 1929
that I last saw her alive on Mar 16, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Thymus Gland Toxemia
"Status Lymphaticus"
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) A. A. Newberry, M. D.
3/16, 1929 (Address) Filer Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Filer Cemetary — Date of Burial Mar 18 1929

20. Undertaker F E Drake — Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65624

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No. 50

(No. County Gen. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arnold Gale Hargis

(a) Residence. No. Filer Ida Route #2 St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 23-1928

7. AGE — Years | 3 Months | 22 Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Twin Falls Ida.

PARENTS

10. NAME OF FATHER: A. T. Hargis

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Colo.

12. MAIDEN NAME OF MOTHER: Margie Lee

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Colo

14. Informant: A. T. Hargis

(Address) Filer Rout #2

15. Filed [illegible], 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

74-0

16. DATE OF DEATH: Mar (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-19, 1929, to 3-19, 1929

that I last saw him alive on 3-19, 1929

and that death occurred, on the date stated above, at 3:50 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Trachea femur.

Bronchi Pneumonia (duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Pomb, M. D.

3-19, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Ida | Date of Burial: Mar 19 1929

20. Undertaker: P. J. Grossman | Address: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65625

PLACE OF DEATH
County of Twin Falls
City of Do.

Registration District No. 7
Primary Registration District No. 1885
Local Registrar's No.
(No. 236 - 9th ave East)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Fletcher

(a) Residence. No. 236 - 9th East St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph Fletcher

6. DATE OF BIRTH (month, day and year) Oct-10-1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	5	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ontario Canada

PARENTS

10. NAME OF FATHER Wm Seabyaugh
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs. V. C. Huntley
(Address) Twin Falls, Idaho

15. Filed 4-1-29, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH 44

16. DATE OF DEATH March 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. [illegible], 1929, to Mch. 20, 1929
that I last saw her alive on Mch. 20, 1929
and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of liver.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. D. Weaver M. D.
3/21, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls cemetery	3/23 1929
20. Undertaker	Address
White Mortuary	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65626

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No. 48

(No. 444 6th Ave E Cal Gen Hosp.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Howard Taylor

(a) Residence, No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 27 / 1913

7. AGE Years: 15 Months: 2 Days: 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ill

PARENTS

10. NAME OF FATHER: G O Taylor

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Orpha Ward

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill

14. Informant: G O Taylor

(Address) Twin Falls

15. Filed 4-10-, 1929 N. Leet Registrar

MEDICAL CERTIFICATE OF DEATH

24
1145

16. DATE OF DEATH: Mar. (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1929, to Mch. 14, 1929

that I last saw him alive on March 14th, 1929

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows: Epidemic Cerebro-Spinal Meningitis

..... (duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Cecil Lewis John Lengelle M. D.

3-18, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetary Date of Burial: Mar 16 1929

20. Undertaker: F E Drake Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65627

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. [illegible]

Primary Registration District No. [illegible]

Local Registrar's No. [illegible]

(No. Twin Falls County Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Horace E. Powers

(a) Residence. No. 252 - 2nd ave north St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Nettie B. Powers

6. DATE OF BIRTH (month, day and year): Sept 16 - 1850

7. AGE: Years 78, Months 5, Days 28. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: U. S. Land Commissioner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Earlville Ill

PARENTS

10. NAME OF FATHER: Norman H. Powers

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. Charlotte Wills

(Address) Los Angeles - Calif

15. Filed 4-10-, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

57

16. DATE OF DEATH: March (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1929, to Mch 13, 1929 that I last saw him alive on March 13, 1929 and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary): Fracture femur

Fall down (duration) yrs. 2 mos. 8 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Bradest - Xray

(Signed) Chas R. Scott, M. D.

Mch 14, 1929 (Address) Twin Falls - Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls cemetery — Date of Burial: Mch 18 1929

20. Undertaker: White Mortuary — Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65628

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 27

Primary Registration District No. 1085

Local Registrar's No. 46

(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nina P. Rawlings.

(a) Residence. No. Yeatman Addition St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Rawlings

6. DATE OF BIRTH (month, day and year): Aug 6 - 1867

7. AGE: 61 Years, 7 Months, 9 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: Andrew Harper.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Armstrong

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: J. W. Rawlings
(Address): T. F. Idaho.

15. Filed 4-10-, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

60

16. DATE OF DEATH: March (Month) 15th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3rd, 1928, to March 5th, 1929 that I last saw her alive on March 15th, 1929 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Goiter Ex opthalmic Acute
++++ (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Acidosis Acute Toxic.
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? B.R. & Laboratory

Exam (Signed) D. L. Alexander M. D.

3/16/29 19 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery — Date of Burial: Mch 18 1929

20. Undertaker: White Mortuary — Address: Twin Falls, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65629

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 31
Primary Registration District No. 1035
Local Registrar's No. 45
(No. at home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Franklin Crump Jr.
(a) Residence. No. Twin Falls R.F.D. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Feb. 1 1929
7. AGE Years Months 1 Days 7 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work (Rancher)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) Twin Falls Ida
(State or country)

PARENTS
10. NAME OF FATHER Geo. F. Crump.
11. BIRTHPLACE OF FATHER (city or town) Idaho.
(State or Country)
12. MAIDEN NAME OF MOTHER Maud Gardner
13. BIRTHPLACE OF MOTHER (city or town) Utah.
(State or Country)

14. Informant Geo. F. Crump.
(Address) Twin Falls Ida

15. Filed 4-10-, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

100-0

16. DATE OF DEATH March 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7, 1929, to March 7, 1929
that I last saw him alive on March 7, 1929
and that death occurred, on the date stated above, at 10a m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [illegible], M. D.
March 7, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial Mar 9 1929
20. Undertaker J. J. Grosseau
Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65630

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No. 44

(No. County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ellis Stowe Wood

(a) Residence. No. Box 176 Kimberly St. Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 11 yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Lilah Wood

6. DATE OF BIRTH (month, day and year): May 1 - 1860

7. AGE: Years 68 Months 11 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Point Bluff Wisconsin

PARENTS

10. NAME OF FATHER: Harvey Concord Wood

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Portsmouth New Hampshire

12. MAIDEN NAME OF MOTHER: Anna Jane Ellis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Woodstock Vermont

14. Informant: Mrs Lilah Wood
(Address) Kimberly Idaho

15. Filed 4-10-, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH 188-C

16. DATE OF DEATH: March (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 3th, 1929, to Mar 6th, 1929 that I last saw him alive on March 5th, 1929 and that death occurred, on the date stated above, at 9-12 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Injury by an auto mobile accident - in country near Kimberly Idaho (duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? At hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Lamb, M. D.

Mar 8, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery — Date of Burial: Mar 10 1929

20. Undertaker: F E Drake — Address: Twin Falls

RECEIVED MAR 13 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

65630

Dr. H.E. Lamb
Twin Falls, Ida.

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

Special Agent, Bureau of Census.

In reference to the death certificate of:

Ellis Stowe Wood who died Mar. 6, 1929
Cause of death given as "Pneumonia" "Injury by an automobile accident."

Information DESIRED in order to complete certificate.

PLEASE STATE WHERE THE ACCIDENT OCCURRED, i.e., county and city or town.

PLEASE ANSWER BELOW

In the country near Kimberly, Twin Falls, Idaho.

Dr H. E. Lamb

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65631

PLACE OF DEATH
County of Twin Falls
City of ..... (If not in city or town, write "Not in city or town")
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No. 43
(No. Co. Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bert W. Magel
(a) Residence. No. 311 3rd Ave North St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 29 1876

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	11	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant & Banker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Conrad Magel
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Mary Newland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill

14. Informant B. T. Magel
(Address) Twin Falls Ida

15. Filed 4-10-, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH 118-b

16. DATE OF DEATH Mar. 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12, 1929, to March 10th 1929, that I last saw h-im alive on March 10th, 1929, and that death occurred, on the date stated above, at 1-12 P.M.

The CAUSE OF DEATH* was as follows:
Post Operative Paralytic Ileus
(duration) yrs. mos. 0 1/2 ds.
CONTRIBUTORY (Secondary) Cholecystectomy for gall stones
(duration) yrs. 1 1/2 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes No. Date of 3-7-29
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) John T. Douglas M. D.
3-12, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Mar. 12 1929
20. Undertaker	Address
C. J. Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65632

PLACE OF DEATH
County of Twin Falls
City of ... (If not in city, write "Not in city")
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No. 432
(No. Co. Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Josephine R. Bryant

(a) Residence. No. 167 Lincoln St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept. 28 1873

7. AGE: Years 53 | Months 5 | Days 9 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nevada.

PARENTS

10. NAME OF FATHER: E. N. Bayer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio.
12. MAIDEN NAME OF MOTHER: Barbra Weaver
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio.

14. Informant: A. A. Bryant
(Address) 167 Lincoln St. City.

15. Filed Apr 12 - 1929 S. N. Lewis Registrar

MEDICAL CERTIFICATE OF DEATH

117

16. DATE OF DEATH: March (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 30, 1924, to March ..., 19...
that I last saw h[illegible] alive on Mar 7th 1924
and that death occurred, on the date stated above, at 8 PM m.
The CAUSE OF DEATH* was as follows:
Cerebral Embolism
(duration) ... yrs. ... mos. 10 hrs ds.
CONTRIBUTORY (Secondary) Acute Gonococcus Pus
Tubaline Appendicitis
(duration) ... yrs. ... mos. 2 ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? Yes Date of Mar 3 - 1924
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. C. Fayle M. D.
Mar 8th, 1924 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Oakland Calif. | Date of Burial 19
20. Undertaker: T. J. Grossman | Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65633

PLACE OF DEATH
County of Twin Falls
City of Do

Registration District No. 24
Primary Registration District No. 1[illegible]
(No. 802 Main South)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. [illegible]

2. FULL NAME William Fridrick Boehm
(a) Residence. No. 802 - Main South St.
(Usual place of abode) (If nonresident give city or town and [illegible])
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Boehm

6. DATE OF BIRTH (month, day and year) April 1st 1835

7. AGE: Years 73, Months 11, Days 7. If LESS than 1 day (1834) hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS
10. NAME OF FATHER: Michael Boehm
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Margaret Hertzel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: L. M. Boehm
(Address) Twin Falls, Idaho

15. Filed 4-12-, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 7 (Month) (Day)

17. I HEREBY CERTIFY, That I attended deceased from July 29, 1928, to Mar 9th that I last saw him alive on Mar 5th and that death occurred, on the date stated above, at 11:[illegible]

The CAUSE OF DEATH* was as follows:
Uremia
(duration) yrs. m[illegible]

CONTRIBUTORY (Secondary) Arteriosclerosis of [illegible] with pistula
(duration) 3 yrs. m[illegible]

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H E Lomb
Mar 8, 1929 (Address) Twin F[illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls cemetery
Date of Burial: Mch[illegible]

20. Undertaker: White Mortuary
Address: Twin [illegible]

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Twin Falls State IDAHO Registered No. 65633
Township ____ or Village ____ or
City Twin Falls No. 802 Main South St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Fridrick Bochin

(a) Residence. No. 802 Main So. St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M	W	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	73	11	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) ____
(State or country) Illinois

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) ____
(State or country) Germany
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) Germany

14 Informant ____
(Address)

15 Filed ____, 19 ____
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 7 1929

17 I HEREBY CERTIFY, That I attended deceased from July 29 1928, to Mar. 7 1929, that I last saw h-im alive on Mar. 5 1929, and that death occurred, on the date stated above, at 11:P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ____ yrs. ____ mos. 1 ds.

CONTRIBUTORY (SECONDARY) ____
(duration) 5 yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) H.E. Lamb, M. D.

, 19 (Address) Twin Falls, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED MAR 26 1929

Registration District No. 15

County of Valley

Primary Registration District No.

File No. 65634

City of Cascade

(No. ..... St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Billy Cleveland Kibby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word)

6. DATE OF BIRTH: Dec (Month) 17 (Day) 1928 (Year)

7. AGE: ..... Yrs. ..... Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cascade Idaho

10. NAME OF FATHER: G C Kibbey

11. BIRTHPLACE OF FATHER (State or Country): Hoskins Oregon

12. MAIDEN NAME OF MOTHER: Eva S Kibby

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. C. Kibbey

(Address)

15. Filed ..... 19 ..... Stella Cain, Local Registrar

MEDICAL CERTIFICATE OF DEATH

161

16. DATE OF DEATH: Jan (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 27 1928, to Jan 13 1929, that I last saw him alive on Jan 10 1929, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Premature Birth.

Bronchial Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ✓

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N. A. Olsen M. D.

..... 19 ..... (Address) Cascade

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19 .....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED MAR 26 19[illegible]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley

City of Roseberry

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. , St.)

File No. 65635

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Cusdava Kaka

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem. 85

4. COLOR OR RACE White

5. ~~SINGLE, MARRIED,~~ WIDOWED ~~OR DIVORCED~~ Widowed (Write the word.)

6. DATE OF BIRTH Nov. (Month) (Day) 1844 (Year)

7. AGE 85 Yrs. 3 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Hco.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Finland

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (State or Country) Finland

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Gus Maki

(Address) ~~Roseberry~~ Norwood

15. Filed 19

Stella Caine
Local Registrar

MEDICAL CERTIFICATE OF DEATH 205

16. DATE OF DEATH Feb. (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No attendence 19 , that I last saw h alive on 19 , and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: not known.

(Duration) ✓ Yrs. mos. ds.

Contributory (Secondary)

(Duration) ✓ yrs. mos. ds.

(Signed) N. A. Olsen M. D.

19 (Address) Cascade, County Physician

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL 19

20. UNDERTAKER Wm McBratney by Mrs A. D. Abbott.

ADDRESS Boise, Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A RECEIVED MAR 26 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley

City of Cascade Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. , St.)

File No. 65636

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eugene A. Jamison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March (Month) 19 (Day) 1867 (Year)

7. AGE: 61 Yrs. 10 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Petaluma Calif

10. NAME OF FATHER: John C Jameson

11. BIRTHPLACE OF FATHER (State or Country): Winchester Iowa

12. MAIDEN NAME OF MOTHER: Mary Jane Lefever

13. BIRTHPLACE OF MOTHER (State or Country): Kilburn Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. Lefever

(Address) Cascade Idaho

15. Filed ..... 19 .....

Stella Cain
Local Registrar

MEDICAL CERTIFICATE OF DEATH 129

16. DATE OF DEATH: Feb. (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 26 1929, to Feb. 2 1929, that I last saw him alive on 2/2 1929, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

chronic nephritis

cardiac decompensation

(Duration) 16 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N. A. Olsen M. D.

3/13 1929 (Address) Cascade

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cascade Idaho

DATE OF BURIAL: Feb 4 1929

20. UNDERTAKER: Wm M Bratney

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

65637

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65637

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 IV-0
Local Registrar's No. 63

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jesse Howard Wilson.
(a) Residence. No. ~~Idaho~~ Canal & 2 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alvina Wilson.
6. DATE OF BIRTH (month, day and year) Nov 10. 1883.
7. AGE Years 45 Months 4 Days 8 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Civil Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Blue Rock. Ohio.

PARENTS
10. NAME OF FATHER W. H. Wilson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.
12. MAIDEN NAME OF MOTHER Mary ? —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant Mrs Alvina Wilson.
(Address) Idaho Falls. Ida.
15. Filed Mar 19, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 18 1929.
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on ....., 19.....
and that death occurred, on the date stated above, at 12 Mid. day.
The CAUSE OF DEATH* was as follows:
Carcinoma Liver
..... (duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) Carcinoma Descending Colon
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of Oct-1926
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) [signature], M. D.
Mar 19, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida — Date of Burial: 3/21 1929
20. Undertaker: V. F. McHan — Address: Idaho Falls Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

65638

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65638

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 56

2. FULL NAME Robert M. Clemons
(a) Residence. No. 1320 Warm Springs St. Ave
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Black
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Daisy A. Clemons

6. DATE OF BIRTH (month, day and year): Nov. 30 - 1877

7. AGE: Years 51, Months 4, Days 16. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Porter at
(b) General nature of industry, business, or establishment in which employed (or employer): Owhyee Hotel
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Tennessee

PARENTS
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown
12. MAIDEN NAME OF MOTHER: Octavia Clemens
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn

14. Informant: Mrs Daisy A Clemons
(Address) 1320 Warm Springs Ave Boise Ida

15. Filed 4/18/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct., 1928, to April, 1929
that I last saw him alive on April 16, 1929
and that death occurred, on the date stated above, at 4:45 p. m.
The CAUSE OF DEATH* was as follows:
Tuberculosis - Epididymus
" Spine (12D)
" Meninges
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Tbc Meningitis
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Lab confirmation
(Signed) M. J. Fuendeling D.
April 17, 1929 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cumberland Human Tenn
Date of Burial: Apr 22 1929

20. Undertaker: Summers & Krebs
Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

65639

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65639

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No.
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar

2. FULL NAME Delbert B. Hartley
(a) Residence. No. Morris Blk. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Grace Hartley
6. DATE OF BIRTH (month, day and year) Feb 8 1894
7. AGE Years 35 Months — Days 27 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer) Car Dept.
(c) Name of employer Canyon Prairie R. R. Co.
9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10. NAME OF FATHER John Hartley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Carolina
12. MAIDEN NAME OF MOTHER Mary Noland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind.

14. Informant Mrs Grace Hartley
(Address) Morris Blk. Lewiston Idaho.
15. Filed Apr 8, 1929 Ap Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 7 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1929, to March 7, 1929
that I last saw him alive on March 7, 1929
and that death occurred, on the date stated above, at 5:00 p. m.
The CAUSE OF DEATH* was as follows:
Empyema.
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Influenza. Pneumonia
(duration) yrs. mos. 1½ ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no. Date of —
Was there an autopsy? no.
What test confirmed diagnosis? Physical signs
(Signed) William [illegible], M. D.
March 7, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Ida
Date of Burial Mar 12 1929
20. Undertaker Vassar Mortuary
Address Lewiston Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

65640

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65640

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 214-0
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 40

2. FULL NAME William James Clegg
(a) Residence. No. Ucon, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary E. Clegg

6. DATE OF BIRTH (month, day and year) March 22-1864

7. AGE Years 65 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Heber City, Utah

PARENTS
10. NAME OF FATHER William Clegg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Louisa Gittins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Albert Clegg
(Address) Ucon, Idaho

15. Filed Apr 11, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28, 1929, to April 10, 1929
that I last saw him alive on April 9, 1929
and that death occurred, on the date stated above, at 1:30 a.m.
The CAUSE OF DEATH* was as follows:
Encephalitis (Influenzial)
(duration) ..... yrs. ..... mos. 19 ds.
CONTRIBUTORY (Secondary) Renal Insufficiency.
(duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Ucon Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical. P.S.P. test
(Signed) H D Fuehler, M. D.
April 10, 1929 (Address) Idaho Falls St

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Ucon, Idaho
Date of Burial April 11 1929

20. Undertaker Jack T. Wood
Address Idaho Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

1-30-67

IDAHO DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
FEB 6 1967
Bureau of Vital Statistics

State of ..... } ss.
County of ..... }

Certificate No. 65640

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for William James Clegg (Name on Original Certificate) who died (Was Born or Died) on April 10, 1929 (Date of Event)
in Idaho Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 12 Maiden name of mother	?	Louisa Gittins

Subscribed and sworn to before me this 30 day of January, 19 67

Notary Public, residing at Eagle, Idaho

My commission expires Sept 30, 1968
(Seal)

Signed Albert Henry Clegg
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Box 154 - Ucon, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of ..... } ss.
County of ..... }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this ..... day of
..... , 19 .....

Notary Public, residing at .....

My commission expires .....
(Seal)

Signed .....
(Signature of Any Credible Person)

.....
(Street Address, City, State)

FORM DH 60-155

1 Cp pd rec # 6194

RECEIVED APR 20 1929

65641

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65641

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Payette

City of Payette

Registration District No. 4

Primary Registration District No. 1008

(No. .....)

Local Registrar's No. 14

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Record Clark

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Edith Clark

6 DATE OF BIRTH (month, day and year): Oct 29

7 AGE: Years 47 | Months 5 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ark

PARENTS

10 NAME OF FATHER: Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ky

12 MAIDEN NAME OF MOTHER: Elizabeth Hogan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ark

14 Informant: Edith Clark
(Address) Payette Ida

15 Filed: Apr 10, 1929. J. C. Woodward, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Apr (Month) 3 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Gunshot wound self inflicted (suicide

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) I. H. Adair (Coroner) M. D.

Apr 4, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Payette Ida

Date of Burial: Apr 26 1929

20. Undertaker: I. H. Adair, Atherson Furn Co

Address: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

65642

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65642

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 139
(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. Eugenio Benito Oguiza
(a) Residence. No. 613 Tesla St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. ~~COLOR OR RACE~~: Single
5. Single, Married, Widowed, or Divorced (write the word): White
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year): 1882
7. AGE: About 47 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sheep Herder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: John Bastida
9. BIRTHPLACE (city or town) (State or country): Spain

PARENTS
10. NAME OF FATHER: Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Spain
12. MAIDEN NAME OF MOTHER: Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Spain

14. Informant: Benito Yswasa
(Address) Boise

15. Filed 4/24/1929 Paula McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4, 1929, to April 22, 1929
that I last saw him alive on April 22, 1929
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Tick fever
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Geo Collins M. D.
..., 19... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Johns Cemetery | Date of Burial: 4/24 1929
20. Undertaker: Schreiber & McCann | Address: Boise, Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 26 1929

65-643

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65643

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 96
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
Local Registrar's No. 47
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Walker S. McCoy

(a) Residence. No. ..... St. Clover, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6 DATE OF BIRTH (month, day and year) April ## 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Humbolt Wells, Nevada

PARENTS
10 NAME OF FATHER Unascertained
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unascertained
12 MAIDEN NAME OF MOTHER Unascertained
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unascertained

14 Informant Records: Northern Idaho Sanitarium
(Address) Orofino — Idaho.

15 Filed 4/18, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 17 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from October 31, 1928, to April 17, 1929, that I last saw him alive on April 17, 1929, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction.
..... (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) Paranoia.
..... (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted ✓ if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John Irvine McKelvey, M. D.
April 18, 1929 (Address) Orofino - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Orofino Idaho	4/19 1929
20. Undertaker W. A. Spaun	Address Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

65644

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65644

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 45-

2. FULL NAME Wilbur T. Ball

(a) Residence. No. ..... St. Coeur d'Alene, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ✓ yrs. ✓ mos. 10 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6 DATE OF BIRTH (month, day and year) April 19, 1905

7 AGE: Years 24 | Months 11 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer in planing mill.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Del Rio - Tennessee

PARENTS

10 NAME OF FATHER: Thomas Allen Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country): Asheville, North Carolina

12 MAIDEN NAME OF MOTHER: Flora Lee Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Marshall, North Carolina

14 Informant: Records: Northern Idaho Sanitarium
(Address) Orofino — Idaho.

15 Filed April 14, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 13 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1929, to April 13, 1929, that I last saw him alive on April 12, 1929, and that death occurred, on the date stated above, at 5.55 A. m.

The CAUSE OF DEATH* was as follows:
Exhaustion of psychosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dementia praecox - Catatonic type. (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical signs

(Signed) John Irvine McKelway, M. D.
April 13, 1929 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Coeur d'Alene Ida
Date of Burial: 19

20. Undertaker: [signature]
Address: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

65-6445

Form V. S. No. 5 20M.1-16-12 MAY 3 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Jerome

Primary Registration District No.

File No. 65645

City of Jerome (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Loren L Main

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Oct (Month) 4 (Day) 1876 (Year)

7. AGE: 52 yrs. 3 mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Andrew Parker Main

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Elizabeth Hack

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H H Main
(Address) Jerome

15. Filed 1/26 1929. Chas F Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 26. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1928, to Jan 15 1929, that I last saw h im alive on Jan 15 1929, and that death occurred on the date stated above, at 12 40 P. M.

The CAUSE OF DEATH* was as follows:

Cancer Stomach

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. P. Zeller M. D.

1/26 1929 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Reno Nev

DATE OF ~~BURIAL~~ Removal 191

20. UNDERTAKER: D A Peterson

ADDRESS: Jerome Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED MAY 7 1929

65646

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65646

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No. Co. Twin Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Parker E. Brainer

(a) Residence. No. Colonial apts City St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W Lite
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 23 1903

7. AGE: Years 25 | Months 8 | Days 15 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Newspaper editor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Idaho Evening Times

9. BIRTHPLACE (city or town) (State or country) Portland Ore.

PARENTS

10. NAME OF FATHER Chas E. Brainer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kans.
12. MAIDEN NAME OF MOTHER Lola Edwards
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon

14. Informant Chas E. Brainer
(Address) Portland Oregon

15. Filed May 10, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14, 1929, to Apr 18, 1929, that I last saw him alive on Apr 18, 1929, and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:
Shock and peritonitis from injuries received in auto accident on Apr 14-29
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Apr 16-29
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical
(Signed) E. G. Barg, M. D.
Apr 18, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Portland Ore	19
20. Undertaker	Address
J. J. Freeman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

65647

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65647

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Latah
City of Moscow

Registration District No. 101
Primary Registration District No. 1011
(No.) Local Registrar's No. 22

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. **FULL NAME** Rodney Philo Drury

(a) Residence. No. 406 Jefferson St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ora B Drury Cora B. Drury

6 DATE OF BIRTH (month, day and year) April 5, 1847

7 AGE: Years 82 | Months | Days 6 | If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED Farmer
(a) Trade, profession, or particular kind of work ~~Clerk~~ (retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Highgate Vt.

PARENTS
10 NAME OF FATHER Philo Drury
11 BIRTHPLACE OF FATHER (city or town) (State or country) Vt.
12 MAIDEN NAME OF MOTHER Bliss
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vt.

14 Informant Mrs. R.P. Drury
(Address) Moscow, Idaho

15 Filed 4-12, 1929 W H Carthers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 11, 1929 (Month) (Day) 19__ (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feby 14, 1929, to Apr 9, 1929, that I last saw him alive on Apr 9, 1929, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows: Myocarditis - Nephritis Hyper Prostate
(duration) some yrs. some mos. ___ ds.

CONTRIBUTORY (Secondary) Senility
(duration) 3 yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Hellers, Rectal
(Signed) C. Magee M. D.
4/12, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, ~~Cremation, or Removal~~ Moscow
Date of Burial 4/13 1929

20. Undertaker F. R. Short
Address Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

65648

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65648

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 45
(No. U. S. Veterans' Hospital, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Herbert F. Simonson

(a) Residence. No. Burke, Idaho St. Burke, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Mae Simonson

6. DATE OF BIRTH (month, day and year) 2-3-1892

7. AGE	Years	Months	Days	If LESS than 1 day,
	37	3	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Truck driver
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) S. Dak.

PARENTS

10. NAME OF FATHER Ben Simonson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx
12. MAIDEN NAME OF MOTHER Nellie Ratcliff
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant M. Cornelius
(Address) U. S. Vet. Hospital, Boise, Idaho

15. Filed 5/9, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 8, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1928, to May 8, 1929
that I last saw him alive on May 8, 1929
and that death occurred, on the date stated above, at 11:25 A. m.
The CAUSE OF DEATH* was as follows:

Pneumonia, Streptoccocus, double
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Tuberculosis, general
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? Yes.
What test confirmed diagnosis?
(Signed) F. B. Brewer, M. D.
Reg. No. [illegible]
U.S.Vet.Hospital, Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Spokane, Wash.	
20. Undertaker W. McBratney	Address Boise, Ida.

65649

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65649

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. ---
(No. U. S. Veterans' Hospital, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

C

2. FULL NAME David RIACH

(a) Residence. No. Buhl, Idaho St. Buhl, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. X yrs. X mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of xx

6. DATE OF BIRTH (month, day and year) 9-23-1894

7. AGE	Years	Months	Days	If LESS than 1 day,
	34	7	14	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheepherder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10. NAME OF FATHER George Riach
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Elizabeth McDonald
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant M. Cornelius
(Address) U.S.Vet.Hospital, Boise, Idaho

15. Filed 5/8, 1929 W. R. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18, 1929, to May 7, 1929, that I last saw him alive on May 7, 1929, and that death occurred, on the date stated above, at 9:05 P.M.

The CAUSE OF DEATH* was as follows:

Mediastinal Tumor. Type undetermined
Probably Malignant.
NOTE: AUTOPSY REQUESTED TO DETERMINE TYPE OF INVOLVEMENT BUT REFUSED BY BROTHERS.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F. B. Brewer, M. D.
Reg. Asst. Surg. Off.
U.S.Vet.Hospital, Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl, Idaho	19
20. Undertaker: McBratney & Co.	Address: Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65650

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No.) 4
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 124

2. FULL NAME Charles H. Clemens
(a) Residence. No. 1808 Boise ave ~~St.~~ Boise, 39 years
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Laura B. Clemans

6. DATE OF BIRTH (month, day and year) Aug 10 - 1858

7. AGE Years 70 Months 8 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner and
(b) General nature of industry, business, or establishment in which employed (or employer) Mill Right
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS
10. NAME OF FATHER Joel Clemans
11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia
12. MAIDEN NAME OF MOTHER Elethia Wolf
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) W. Virginia

14. Informant Harry L. Clemans
(Address) 1806 Boise Ave

15. Filed 4/5/29 19 Paula M. Donald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1928, to Apr 4, 1929
that I last saw him alive on Apr 4, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Bronchial Asthma
(duration) ? yrs. mos. ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? usual
(Signed) Dutoney, M. D.
4/5, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial 4/7 1929

20. Undertaker Schneider & McCann
Address Boise, Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65651

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 123

(No. U.S.Veterans' Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oscar P. Friley

(a) Residence. No. ..... St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

4

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Doty Friley

6. DATE OF BIRTH (month, day and year): Oct. 8, 1890

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
38	5	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Texas

PARENTS

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: D.W.Herron

(Address) U.S.V.Hospital, Boise, Idaho

15. Filed 4/8/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 5, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1928, 19, to Apr. 5, 1929, 19

that I last saw him alive on Apr. 5, 1929, 19

and that death occurred, on the date stated above, at 7:55 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): pulmonary hemorrhage

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) F.B.Brewer, M. D.

Apr. 6, 1929, 19 F.B.Brewer
Medical Officer in Chg.
U.S.V.Hosp., Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bryan, Texas

Date of Burial: 4-6-29 19

20. Undertaker: W.McBratney

Address: Boise, Idaho

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65652

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 120

11

2. FULL NAME Clara Gray
(a) Residence. No. 1311 Bannock St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Gray

6. DATE OF BIRTH (month, day and year) March 12 - 1870

7. AGE Years 59 Months 1 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER ? Fendsham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Am.
12. MAIDEN NAME OF MOTHER Julia Zaberosky
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Am.

14. Informant Viva Gray
(Address) 1311 Bannock

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1929, to April 26, 1929
that I last saw her alive on April 26, 1929
and that death occurred, on the date stated above, at 7:20 P m.
The CAUSE OF DEATH* was as follows:
Bony Metastases + Toxemia from Carcinoma of Breast Previously Removed 2 yrs ago
(duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) Severe Secondary anaemia
(duration) ..... yrs. 4 mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of 1927
Was there an autopsy? yes
What test confirmed diagnosis? autopsy
(Signed) G. H. Wahle, M. D.
....., 19.... (Address) 515 Eastman Bldg Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial 4/30 1929

20. Undertaker Schreiber & McCann
Address Boise, Ida

Wahle

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65653

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 119

11

2. FULL NAME Alice Heron Covell
(a) Residence. No. ..... St. Hagerman Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Covell

6. DATE OF BIRTH (month, day and year) July 7-1873

7. AGE Years 55 Months 9 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho

PARENTS
10. NAME OF FATHER David Heron
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Fidelia Canfield
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Conn

14. Informant Charles H. Covell
(Address) Hagerman Idaho

15. Filed 5/2/ 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 30, 1929
Oct. 15 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1929 to April 30, 1929
that I last saw her alive on April 30, 1929
and that death occurred, on the date stated above, at 11 50 a.m.
The CAUSE OF DEATH* was as follows:
Carcinomatosis following Breast Amputation
..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of April 1927
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy & Microscope
(Signed) Ernest E. Lanbaugh, M. D.
4/30/29, 19..... (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial May 2 1929

20. Undertaker Summers & Krebs
Address Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929 Dr Pittinger - Dr Coleman

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65654

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 118

2. FULL NAME Alfred Moser 4

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan-22-1919

7. AGE Years 10 Months 3 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Medina North Dakota

PARENTS
10. NAME OF FATHER L F Moser
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Christina Gohl
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant L. P. Moser
(Address) Kuna Idaho

15. Filed 4-29-1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-16-, 1929, to 4-27, 1929
that I last saw him alive on 4-25, 1929
and that death occurred, on the date stated above, at 7-10 A m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) - yrs. - mos. - ds.

CONTRIBUTORY (Secondary) -

(duration) - yrs. - mos. - ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of -
Was there an autopsy?
What test confirmed diagnosis? Blood Count and X-Ray
(Signed) F J Coleman, M. D.
19 (Address) Kuna Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery
Date of Burial: April 29 1929
20. Undertaker: W D Mather
Address: Meridian Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65655

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 117

(No. 1611 West Jefferson Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clarence A. Warner.

(a) Residence. No. 1611 West Jefferson St.
(Usual place of abode)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

3 R

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Nellie Warner.

6. DATE OF BIRTH (month, day and year) Sept. 7th 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	7	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 2nd Hand Furniture Store.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Burlingame, Kan.
(State or country)

PARENTS

10. NAME OF FATHER Horatio N. Warner

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Jane Northrop

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant Mrs. C. A. Warner.

(Address) Boise, Idaho.

15. Filed 4/26/29 Paula McDonnell
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 22nd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1929, to April 22nd, 1929
that I last saw him alive on April 22nd, 1929
and that death occurred, on the date stated above, at 10. P.M. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
First Hemorrhage April 16th 29.
Second Hemorrhage April 22nd 29.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) High blood pressure

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

4/24/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	4/26/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65656

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 116
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Mores
(a) Residence. No. 301 Grove St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

11 R

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): 1844

7. AGE: About Years 85 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Am.

PARENTS
10. NAME OF FATHER: Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Wm M Cook
(Address) Boise.

15. Filed 4/24, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to 4/22, 1929
that I last saw him alive on 4/21, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Exhaustion
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Carcinoma of Prostate
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 1/3/29
Was there an autopsy? No
What test confirmed diagnosis? Clinical Symptoms
(Signed) Fred. A. Fuenger M. D.
4/23, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Johns Cemetery — Date of Burial: 4/24 1929.

20. Undertaker: Schreiber & McCann — Address: Boise, Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65657

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 715

(No.) St Alphonsus Hospital

(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME William M Jewell

(a) Residence. No. Wilder Idaho St. Wilder Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 11 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	0	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Jacob C Jewell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Margaret E Buck

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Charlie Jewell

(Address) Wilder Idaho.

15. Filed 4/24/1929 Paula M Donaca Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 11, 1929 to Apr 19, 1929 that I last saw him alive on Friday 4/19, 1929 and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Spotted Fever -

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical findings

(Signed) Alphonsus Hospital, M. D.

Apr 22, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sweet Idaho	Apr 24 1929
20. Undertaker	Address
Summers & Rebe.	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Pittenger

DO NOT WRITE IN THIS SPACE
State File No. 65658

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 114

PLACE OF DEATH

County of Ada
City of Boise
(No. St Alphonsus Hospital,)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Marion Sebern 3

(a) Residence. No. 2 miles West of Boise St.
(Usual place of abode)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 20-1883

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	4	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hardware Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colorado

PARENTS

10. NAME OF FATHER Milton H Sebern
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Sarah M Heath
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant M H Sebern
(Address) Boise Idaho R 2

15. Filed 4/8/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1928, to 4/5, 1929
that I last saw him alive on 4/5, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Symptoms

(Signed) Fred A Pittenger M. D.
4/6, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hillcemetery	Apr 8 1929
20. Undertaker	Address
Summers & Krebs	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65659

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 113

2. FULL NAME James Wesley Draper
(a) Residence. No. St Alphonsus St., Bellevue 12 Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Olivia Draper

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36	8	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Payette Ida

PARENTS

10. NAME OF FATHER John Wesley Draper
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Mary Harrington
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Ora Tilley
(Address) Fairmont Ida

15. Filed 5/8/29 19 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 7, 1929, to Apr 7th, 1929
that I last saw him alive on Apr 7, 1929
and that death occurred, on the date stated above, at 3.50 m.
The CAUSE OF DEATH* was as follows:
Auto accident, Crushing Injury of left chest
(duration) yrs. mos. 1 hr.
CONTRIBUTORY (Secondary) Shock & Internal Hemorrhage (duration) yrs. mos. 1 hr.

18. Where was disease contracted if not at place of death? Ada County
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. M. Bradshaw, M. D.
Apr 8, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Council Ida	4/9/29
20. Undertaker	Address
Churchill & McCown	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65660

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 112
(No.) St Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edith V. Dobson
(a) Residence. No. Near Horseshoe Bend Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jim Dobson
6. DATE OF BIRTH (month, day and year): July 13 1880
7. AGE: Years 48 | Months 8 | Days 25 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): California

PARENTS
10. NAME OF FATHER: John P. Freeman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Mary Abbey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Jim Dobson
(Address) Horseshoe Bend Idaho
15. Filed 4/11/, 1929 Paula M. Doland Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8th (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 24th, 1929, to April 8th, 1929
that I last saw h~~e~~ alive on April 8th, 1929
and that death occurred, on the date stated above, at 3 40 P m.
The CAUSE OF DEATH* was as follows:
Left cerebral hemorrhage
(Recurrent)
(duration) yrs. mos. 16 ds.
CONTRIBUTORY (Secondary) Arterio-sclerosis
(duration) 3 yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) B. W. Lathen, M. D.
Apr. 9th, 1929 (Address) 218 Eastman Bldg Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Apr 10 1929
20. Undertaker: Summers & Rebo — Address: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Burier

DO NOT WRITE IN THIS SPACE
State File No. 65661

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 111
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eunice T. Folsom
(a) Residence. No. 208 Bannock St. 4
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) July 24 - 1844
7. AGE Years 84 Months 8 Days 10, If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a). Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Vermont.

PARENTS
10. NAME OF FATHER Eber Dunham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont
12. MAIDEN NAME OF MOTHER Lucy Jewett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vermont

14. Informant T. T. Folsom
(Address) 208 Bannock St. Boise Ida
15. Filed 4/8/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 4 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from , 1926, to April 4, 1929
that I last saw her alive on March 3, 1929
and that death occurred, on the date stated above, at 5:15 P.m.
The CAUSE OF DEATH* was as follows:
Hypostatic Pneumonia
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Senility + Paraplegia
(duration) 13 yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) C. T. Irving, M. D.
4/6, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pioneer Cemetery
Date of Burial: April 6 1929
20. Undertaker: Summers & Krebs
Address: Boise Idaho

Albert Borck RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65662

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 110

(No. 1512 Oakland St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

5

2. FULL NAME Mrs. Nellie Ridemour.

(a) Residence. No. 1512 Oakland St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: J. A. Ridenour.

6. DATE OF BIRTH (month, day and year): December 1st 1867

7. AGE: Years 61 | Months 4 | Days 10 | If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Racine, Wisconsin.

PARENTS

10. NAME OF FATHER: Harvey Randall.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Estella

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Chicago, Ill.

14. Informant: J. A. Ridenour.
(Address): Boise, Idaho.

15. Filed 4-13-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 11th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Mar 18, 1929, to April 11, 1929 that I last saw her alive on April 11, 1929 and that death occurred, on the date stated above, at 6 P.M m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach and intestines

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A B Borck, M. D.

4/12/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: 4/13/29 19

20. Undertaker: Wm. McBratney. | Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65663

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 109
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Kate Gabriel 3
(a) Residence. No. 1118 Lemp St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 59 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Gabriel
6. DATE OF BIRTH (month, day and year) Oct. 32 1852
7. AGE Years 76 Months 6 Days 6 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Andrew Spies
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Ida E. Grant
(Address) Boise, Ida

15. Filed 4-12-1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 9 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 8, 1929
that I last saw her alive on April 8, 1929
and that death occurred, on the date stated above, at 6:30 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) — yrs. 6 mos. — ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. A. Koelsch, M. D.
4/12, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. Johns Cemetery — Date of Burial 4/12 1929
20. Undertaker Schneider & McCann — Address Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Jones gm

RECEIVED MAY 6 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65664

Registration District No. 2

Primary Registration District No. 1014

Local Registrar's No. 108

(No. St Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lena Caroline Patterson 1

(a) Residence. No. 2 Miles West of Boise St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ray H. Patterson.

6. DATE OF BIRTH (month, day and year) May. 20-1894

7. AGE Years 34 Months 10 Days 18 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Frank Kindeberger

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Mary Fleming

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Ray H. Patterson.
(Address) Boise Idaho. R D #1

15. Filed 4/8/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from apr 1, 1929, to apr 8, 1929

that I last saw her alive on apr 8 1929

and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Generalized meningitis caused by mastoid. & Pan sinus infect side

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mastoid & Sinus

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Arthur Jones M. D.

5/9, 1929 (Address) Eye Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery — Date of Burial Apr 10 1929

20. Undertaker Summers & Krebs — Address Boise Idaho

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65665

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 107

(No. 1803 N. 9th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Mary Elizabeth Kent.

(a) Residence. No. 1803 N. 9th Street. St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

9 R

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William V. Kent

6. DATE OF BIRTH (month, day and year) April 6th 1848

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	II	5	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Keokuk, Iowa.

PARENTS

10. NAME OF FATHER John Brown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.

12. MAIDEN NAME OF MOTHER Abigail Gibson.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ky.

14. Informant Mrs. Sherman Vance.

(Address) Boise, Idaho.

15. Filed 4/21, 1929 Paula McDonagh Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1929, to 4/1, 1929 that I last saw h-er alive on 3/31, 1929 and that death occurred, on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fred A Bramble, M. D.

4/2/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Oswego, Kansas.	19

20. Undertaker Wm. McBratney Address Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

Genoway Dm

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65666

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 106
(No. St Alphonsus Hospital.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Greeley Julien 3
(a) Residence. No. 1409 Washington St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 21-1855

7. AGE Years 74 Months 0 Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. M. J. Morris
(Address) 1409 Washington St. Boise Ida

15. Filed 4-6-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-, 1928, to April 5th, 1929
that I last saw him alive on April 4, 1929
and that death occurred, on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Chronic Mitral valve heart lesion
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) File
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? yes
(Signed) Chas V Gennuy, M. D
April 6, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial April 6 1929

20. Undertaker Gemmers & Krebs
Address Boise Idaho

Dr. Almond

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65667

PLACE OF DEATH
County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 105
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Pierce Stoddard.

(a) Residence. No. 1806 Harrison Blvd. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Stoddard.

6. DATE OF BIRTH (month, day and year) July 5th 1852

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	9	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Methodist Minister.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York City.

PARENTS

10. NAME OF FATHER William Stoddard.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York.
12. MAIDEN NAME OF MOTHER Louisa Morgan.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York.

14. Informant I. W. Stoddard.
(Address) Boise, Idaho.

15. Filed 4/20/, 1929 Paula McBones Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 18th 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from March, 1928, to April 18, 1929
that I last saw him alive on 4-18, 1929
and that death occurred, on the date stated above, at 9:25 P.M.
The CAUSE OF DEATH* was as follows:
Uraemia

(duration) yrs. 2 mos. — ds.
CONTRIBUTORY (Secondary) Hypertrophy of prostate
(duration) 4 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? St Lukes
Did an operation precede death? yes Date of 4-11-29
Was there an autopsy? yes
What test confirmed diagnosis? Renal function
(Signed) I W Almond, M. D.
4-19, 1929 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	4/20/29 19

20. Undertaker Wm. McBratney. Address Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65668

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 102

12

2. FULL NAME Walter Willis.
(a) Residence. No. Eagle, Idaho R. #I. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------
6. DATE OF BIRTH (month, day and year)
7. AGE: 36 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farm Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Mo.

PARENTS

10. NAME OF FATHER: T. J. Willis.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: Isabel Diltz.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa.

14. Informant: T. J. Willis.
(Address) Grand Island, Neb.

15. Filed 4/16/, 1929 Paula M. Soaded Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 13th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from March 30, 1929, to April 13, 1929
that I last saw him alive on April 13, 1929
and that death occurred, on the date stated above, at 3:30 P.M.
The CAUSE OF DEATH* was as follows:
Fracture of base of skull with concussion
Automobile Accident
(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Valley Rd. Ada County Ida.
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. A. Koelsch, M. D.
4/13, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grand Island, Nebr. Shipped
Date of Burial: 4/17/29 19

20. Undertaker: Wm. McBratney.
Address: Boise, Idaho

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65669

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 98

(No. 3 C)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eliza Jane Hakes

(a) Residence. No. 1001 State St. St.
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 24-1854

7. AGE: Years 73 | Months 4 | Days 18. | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Rochester New York

PARENTS

10. NAME OF FATHER: John Reed
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Jane Knight
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Jennie M Talby
(Address) 1001 State St Boise Idaho

15. Filed 4/29/1929 Paula M Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 2 - 1929, to — — 1929
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 6 P- m.

The CAUSE OF DEATH* was as follows:
Apoplexy —
Had not attended her. Did not see her till a few minutes after death (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? no test
(Signed) L. M. Taylor, M. D.
Apr 4, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	April 8 1929
20. Undertaker	Address
Summers & Krebs	Boise Ada

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

DO NOT WRITE IN THIS SPACE

State File No. 65670

Local Registrar's No. 101

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Daisy Jean Johnson

(a) Residence. No. 1312 N. 6th. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) April, 11, 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	13	—

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho

PARENTS

10. NAME OF FATHER Sam E. Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Katherine Hanley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Sam E. Johnson

(Address) Boise, Idaho

15. Filed 4/25/1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April, 24, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11 —, 1929, to April 24, 1929

that I last saw her alive on April 22, 1929

and that death occurred, on the date stated above, at 2 P.M. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Premature

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Caccamese-Joplin, M. D.

April, 24, 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	4/24/29 19

20. Undertaker	Address
W. McBratney	Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65671

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 108

(No. 607 N. 8th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

#3

2. FULL NAME Mrs. Merica Weese.

(a) Residence. No. 607 N. 8th Street. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Bernard Weese.

6. DATE OF BIRTH (month, day and year): April 7th 1856

7. AGE: 73 Years | Months: 0 | Days: 19 | If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10. NAME OF FATHER: Paul Marsters.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Safronia Catlin.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ind.

14. Informant: Algie Weese.

(Address) 607 N. 8th Street, Boise.

15. Filed 4/29/, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 26th 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1925, to April 26, 1929

that I last saw her alive on April 26 1929

and that death occurred, on the date stated above, at 10:50 P.M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Mitral Valve Lesion

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? yes

(Signed) Chas V Gaussen M. D.

4/27/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Dry Creek Cemetery. Date of Burial: 4/29/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65672

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 125

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

7

2. FULL NAME Anna Tucker

(a) Residence. No. 1001 N 17 St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 8 - 1858

7. AGE Years 70 Months 4 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER William Fletcher

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Rachel Watson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Mrs. Bernard T. Tuny
(Address) 1001 N. 17 St Boise Idaho

15. Filed 4/17/1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr, 1910, to Apr, 1929 that I last saw her alive on Apr 15, 1929 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) High blood pressure

(duration) 15 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

4/16 (Signed) Dr Tomey, M. D.
1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Apr 17 1929

20. Undertaker: Summers & Krebs — Address: Boise Idaho

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65673

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2008

Local Registrar's No. 25

(No. Idaho State Penitentiary.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ylario Alvarez.

(a) Residence. No. Idaho State Penitentiary St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Convict.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mexico.

PARENTS

10. NAME OF FATHER Don't Know.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Pearl Allen.

(Address) Boise, Idaho.

15. Filed 4-30-29 Paula M. Donald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 29th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 27, to Apr 29, 29
that I last saw him alive on Apl 27, 29
and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine
Pulmonary Tuberculosis

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Feb. 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O H Ruben, M. D.

4/30/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. John's Cemetery	4/30/29 19

20. Undertaker Wm. McBratney. Address Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65674

PLACE OF DEATH
County of Ada
City of Boise Id

Registration District No. 8
Primary Registration District No. 2008
(No.) Local Registrar's No. 24
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isaac Prow
(a) Residence. No. Ada County Hospital St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 17 - 1853

7. AGE: Years 76 Months 3 Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind -

PARENTS
10. NAME OF FATHER Phillip Prow
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Haily Boltenhouse
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant
(Address) Meridian Id

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11, 1928, to Apr 25, 1929
that I last saw him alive on Apr 23, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage and ~~Left~~ Right hemiplegia.
(duration) 3 yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? Ada County
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) T. N. Braxton, M. D.
Apr 26, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery
Date of Burial: April 28 1929

20. Undertaker: N S Mather Meridian
Address

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65675

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2008
(No.)
Local Registrar's No. 23

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cyrus Quincy Rose

(a) Residence. No. 4 miles West of Boise
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 21, 1868 (1868)

7. AGE: Years 60 | Months 6 | Days 3 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nebraska

PARENTS

10. NAME OF FATHER: Benjamin Franklin Rose
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Electa Baylor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: Mrs. Frances Swift
(Address) R. 2, Boise Idaho

15. Filed 4-30-1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April - 24 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ , 19 , to , 19
that I last saw ~~him~~ alive on , 19
and ~~that~~ death occurred, on the date stated above, at 8:45 m.

The CAUSE OF DEATH* was as follows: Dropped Dead: Apoplexy
Natural Cause:
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): No. Inquest held.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) James Bradley - Coroner, M. D.
4/26/29, 19 (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Apr 27 1929
20. Undertaker: Summers & Kebe — Address: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65676

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2008
Local Registrar's No. 22
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lee Smith
(a) Residence. No. Riverside Station St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lena B. Smith
6. DATE OF BIRTH (month, day and year) Jan. 31. 1866.
7. AGE Years 63 Months 2 Days 26. If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS
10. NAME OF FATHER A. Jackson Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Mrs. Lee Smith
(Address) R.D. #1, Boise Idaho
15. Filed 4-29-, 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 27 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July, 1929, to April 27, 1929
that I last saw him alive on April 27, 1929
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:
Anasarca
(duration) yrs. 4 mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) 10 yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) A B Boeck, M. D.
April 29, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Parma Idaho. Date of Burial Apr 29 1929
20. Undertaker Summers & Krebs Address Boise Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65677

PLACE OF DEATH
County of Elmore
City of

Registration District No. 8
Primary Registration District No. 2008
Local Registrar's No. 21
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Henry Bowen.
(a) Residence. No. 2 Miles East of Mayfield Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): 1855
7. AGE: Years 74. Months —. Days —. If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Mississippi

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant J. O Burk
(Address) Mayfield Idaho.
15. Filed 4/30/ 1929 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 27 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jany 24, 1929, to March 28, 1929
that I last saw him alive on March 10, 1929
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Amyloid degeneration of heart
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Geo Collett, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: May 1 1929
20. Undertaker: Drummond & Rule — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65678

PLACE OF DEATH

County of Ada
City of

Registration District No. 8
Primary Registration District No. 2008
Local Registrar's No. 20

(No. 13½ Miles S.W. of Boise.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Josephine Miller.

(a) Residence. No. Meridian, Idaho R#3 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) Aug. 5th 1926

7. AGE Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
2	6	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Herman Miller.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Brookville, Pa.
12. MAIDEN NAME OF MOTHER Ida Hall.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Star, Idaho.

14. Informant Mrs. Herman Miller.
(Address) Meridian, Idaho R#3.

15. Filed 4-17- 1929 Lula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ---- 19--, to ---- 19--
~~that I last saw her~~ alive on ---- 19--
~~and that~~ death occurred, on the date stated above, at 2 P.M. m.

The CAUSE OF DEATH* was as follows:
Accidently killed when Auto in which she was riding turned over crushing her beneath it and causing death instantly
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) No Inquest held.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ----
Did an operation precede death? No Date of ----
Was there an autopsy? No
What test confirmed diagnosis? ----

(Signed) Wm McBratney, Coroner, M. D.
4/14/29, 19-- (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	4/14/29 19

20. Undertaker Wm. McBratney. Address Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65679

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2008

Local Registrar's No. 19

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isham I. Youngblood.

(a) Residence. No. Boise, Idaho. R. #2. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Youngblood.

6. DATE OF BIRTH (month, day and year): Oct. 28th 1866.

7. AGE: 62 Years | Months: 5 | Days: 13 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Mining.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Franklin Co. Ill.

PARENTS

10. NAME OF FATHER: William J. Youngblood.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois.

12. MAIDEN NAME OF MOTHER: Emiline O'Hillen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Franklin Co. Ill.

14. Informant: Mrs. I. I. Youngblood.
(Address) Boise, Idaho. R. #2.

15. Filed 4/17, 1929 Paula McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 11th 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw in ..... alive on ....., 19.....
and that death occurred, on the date stated above, at 3:15 P.M m.

The CAUSE OF DEATH* was as follows:
Dropped dead in road while walking to his home about 2½ miles S. W. of Boise, Idaho. Probably had cerebral Hemorrhage
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): No Inquest held.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Wm McBratney, Coroner, M.D.

4/12/29, 19.... (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: 4/13/29, 19

20. Undertaker: Wm. McBratney. | Address: Boise, Idaho.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65680

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 208
Local Registrar's No. 18

(No. 3 Miles South of Whitney school)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dick Bryan

(a) Residence. No. 3 Miles south of Whitney school.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	Negro Black.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Don't Know.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Ahout 85			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Alabama.

PARENTS

10. NAME OF FATHER Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Pearl Allen.
(Address) Boise, Idaho.

15. Filed 4/25/, 1929. Paula McDonnell
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April - 22 - 1929.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ , 19 , to , 19
~~that I last saw h~~ alive on , 19
~~and that~~ death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Found Dead. Had been in poor health for some time. Natural Cause. No autopsy requested.

CONTRIBUTORY ~~(Secondary)~~ Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No.
What test confirmed diagnosis?

(Signed) Wm McBratney - Coroner, M. D.
4-24-29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
County Cemetery.	4/24/29 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65681

PLACE OF DEATH
County of Ada
City of Boise R 2

Registration District No. 8
Primary Registration District No. 2008
(No. 6)

Local Registrar's No. 17

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Benjamin Franklin Rice

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Electa Rice

6 DATE OF BIRTH (month, day and year) Sept. 13-1837

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
91	7	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Freeport Ill.

PARENTS

10 NAME OF FATHER Jacob Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) D. K.

12 MAIDEN NAME OF MOTHER Hannah Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D. K.

14 Informant Wilbur Swift
(Address) Boise Idaho R 2

15 Filed 4/15/29, 19.. Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. (Month) 12 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 7, 1929, to Apr 12, 1929, that I last saw h.. alive on Apr 12, 1929, and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

0 (duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza & Stroke

(duration) 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. F. Neal, M. D.

4-13, 1929 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Apr. 15 1929
20. Undertaker	Address
Summers & Krebs	Boise Idaho

RECEIVED APR 26 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65682

PLACE OF DEATH
County of Ada
City of Near Star.

Registration District No. 9+10
Primary Registration District No. 9+10
Local Registrar's No. 1
(No. Fourteen Miles West of Boise.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Amos C. Prosser.
(a) Residence. No. Fourteen Miles West of Boise. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Married.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Prosser.
6. DATE OF BIRTH (month, day and year): Sept. 27th 1864
7. AGE: 64 Years, Months: 6, Days: 4. If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS
10. NAME OF FATHER: Jonathan Prosser
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown
12. MAIDEN NAME OF MOTHER: Elvira Cox
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Amy E. Evans.
(Address)

15. Filed April 2, 1929. Orvie Jelcom, Registrar, Eagle Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 1st 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929, to April 1, 1929
that I last saw him alive on April 1, 1929
and that death occurred on the date stated above, at 9:50 PM m.
The CAUSE OF DEATH* was as follows:
Septic Poisoning
(duration) yrs. mos. 35 ds.
CONTRIBUTORY (Secondary): Cordeles & Angina
(duration) 2 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? —
What test confirmed diagnosis? none
(Signed) O. W. Hall, M. D.
4/2/29, 19 (Address) Star, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 4/3/29 19
20. Undertaker: Wm. McBratney
Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65683

PLACE OF DEATH
County of Ida
City of Meridian

Registration District No. 11
Primary Registration District No. 2003
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

2. FULL NAME Helen-May Ellis -
(a) Residence. No. Meridian Id St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, 6 Hours hrs. or ~~6 Hours~~ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Meridian Id

PARENTS
10. NAME OF FATHER: Hershell Ellis -
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Boise Id.
12. MAIDEN NAME OF MOTHER: Ina Evans
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Meridian Idaho

14. Informant: Hershell E. Ellis
(Address) Meridian Idaho

15. Filed Apr 13, 1929 H F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-13-, 1929, to 4-13-, 1929
that I last saw her alive on 4-13-, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows: Premature Birth 8 month
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H F Neal, M. D.
4-13, 1929 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery
Date of Burial: April 14 1929
20. Undertaker: W S Moters Meridian Id
Address

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65684

PLACE OF DEATH
County of ~~Canyon~~ Ada
City of Meridian
Registration District No. 11
Primary Registration District No. 2003
Local Registrar's No. 5

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Maude Ballard

(a) Residence. No. ..... Meridian ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 8 1885

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
43	11	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER John Jacker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa Maryland
12. MAIDEN NAME OF MOTHER Susan Willers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Grant Ballard
(Address) Meridian, Idaho

15. Filed Apr 23, 1929 F. E. Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/1, 1929, to 4-21, 1929
that I last saw her alive on 3/1, 19.....
and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:
Myocarditis
..... (duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....

(Signed) F. E. Neal M. D.
4-23, 1929 (Address) Meridian Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Star	1929
20. Undertaker C. V. Peckham	Address Caldwell, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 1 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65685

Registration District No. 11
Primary Registration District No. 2003
(No. .....)
Local Registrar's No. 6

PLACE OF DEATH
County of Ada
City of Meridian Id

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nancy Jane Tucker

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Henry Tucker

6. DATE OF BIRTH (month, day and year) July 25- 1852

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	9		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Jasper Co Mo

PARENTS

10. NAME OF FATHER Wm T. Lewis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Jane Maberry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Green Co Mo

14. Informant Homer Tucker
(Address) Meridian Idaho

15. Filed April 26, 1929 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 23, 1929, to April 23, 1929
that I last saw her alive on April 23, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
general debility 9 years
Suffered from Chronic
Arthritis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) don't Know
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) W. F. Tucker, M. D.
April 26, 1929 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Cemetery	April 27 1929
20. Undertaker	Address
J B Mater	Meridian Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65686

PLACE OF DEATH

County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5519
(No. GENERAL HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME HAROLD JESSE COOK

(a) Residence. No. NORTH OF CITY St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) APRIL 18, 1910.

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	18	10	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work FARMER
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) REXBURG IDAHO

PARENTS

10. NAME OF FATHER S. MELVIN COOK
11. BIRTHPLACE OF FATHER (city or town) (State or Country) UTAH
12. MAIDEN NAME OF MOTHER CASSIE MILLIKEN
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UTAH

14. Informant SAMUEL MELVIN COOK
(Address) NORTH OF CITY

15. Filed 3/12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
MARCH (Month) 8 (Day) 19 (Year) 29

I HEREBY CERTIFY, That I attended deceased from Feb 18, 1929, to Mch 8, 1929
that I last saw ~~him~~ alive on Mch 8, 1929
and that death occurred, on the date stated above, at 1:30 p. m.
The CAUSE OF DEATH* was as follows: Gangrenous Appendicitis

(duration) yrs. mos. 18 ds.
CONTRIBUTORY (Secondary) General peritonitis
(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death? Farm near Pocatello
Did an operation precede death? Yes Date of Feb. 19, 1929
Was there an autopsy? No
What test confirmed diagnosis? Surgical operation
(Signed) Dr. T. Howard M. D.
3/9, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW	19
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65687

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5520

(No. LYNN HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME LEAL TANNER VOLLMER

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE

4. COLOR OR RACE: WHITE

5. Single, Married, Widowed, or Divorced (write the word): MARRIED

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of EDWARD VOLLMER

6. DATE OF BIRTH (month, day and year) DECEMBER 7. 1897

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
31	3	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work HOUSEWIFE

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) IDAHO

PARENTS

10. NAME OF FATHER THOMAS TANNER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) UTAH

12. MAIDEN NAME OF MOTHER IVY MAY PECK

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UTAH

14. Informant EDWARD VOLLMER
(Address) 526 N. - 11TH AVE

15. Filed 3/12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

205-6

16. DATE OF DEATH MARCH (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 6, 1929, to Mar 9, 1929 that I last saw her alive on Mar 9, 1929 and that death occurred, on the date stated above, at 5-9 m.

The CAUSE OF DEATH* was as follows: Surgical Shock

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) suppression of urine (duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of Mar 7-29

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) [signature], M. D.

3/9/29, 19.... (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: MORELAND IDAHO

Date of Burial: 3/12/29

20. Undertaker: ARTHUR W. HALL

Address: POCATELLO

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

15 Dr Groom.

DO NOT WRITE IN THIS SPACE
State File No. 65688

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5521
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bessie P Frazier.

(a) Residence. No. 356 N 13th ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of W L Frazier

6. DATE OF BIRTH (month, day and year) Dec 19th 1909

7. AGE Years	Months	Days	If LESS than 1 day,
19	3	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER W.C. Cooper.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Laura Garner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Geo N Cooper.
(Address) Pocatello Idaho

15. Filed 3/12, 1929. J H Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5, 1929, to Mar 9, 1929
that I last saw h~~er~~ alive on Mar 9, 1929.
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Influenza &
Pneumonia.
Contracted by Miscarriage.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At Home.
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) C Peirson, M. D.
3/10, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Mt View	
20. Undertaker	Address
Schumacher & Beasley	City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65689

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5522

2. FULL NAME Ruth Anderson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Aug 2 1905

7. AGE: 23 Years, 7 Months, 11 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House keeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Colorado

PARENTS

10. NAME OF FATHER: John H. Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Anna Hanson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Colorado

14. Informant: John H. Anderson
(Address) Gibson, Idaho.

15. Filed Mar 13, 1929 J. D. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8, 1929, to Mar 13, 1929
that I last saw her alive on Mch 12, 1929
and that death occurred, on the date stated above, at 9.30 a. m.
The CAUSE OF DEATH* was as follows:
Meningitis Spinal, meningococcic Contagious
(duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary): Toxemia and Exhaustion
(duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? Gibson, Idaho
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical and Laboratory
(Signed) W. T. Howard, M. D.
3/13, 1929 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Idaho
Date of Burial: Mar 14 1929

20. Undertaker: McHan Undt Co
Address: Pocatello Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65690

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. GENERAL HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5523

2. FULL NAME HENRY HURST WOOD
(a) Residence. No. REXBURG IDAHO St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): MARRIED

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ ELIZABETH HENDRY

6. DATE OF BIRTH (month, day and year) OCT. 1 1874

7. AGE: Years 54, Months 5, Days 7. If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: FARMER
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): WELLSVILLE UTAH

PARENTS

10. NAME OF FATHER: GEORGE WOOD
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ENGLAND
12. MAIDEN NAME OF MOTHER: MARY HURST
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ENGLAND

14. Informant: MRS. HENRY H. WOOD
(Address) REXBURG IDAHO

15. Filed 3/16, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26, 1929, to March 12, 1929
that I last saw him alive on March 12, 1929
and that death occurred, on the date stated above, at 1:30 p.m.
The CAUSE OF DEATH* was as follows:
Septicemia from sinuses tonsils and teeth
(duration) yrs. 1 mos. 15 ds.
CONTRIBUTORY (Secondary) Operation - Extraction of teeth
(duration) yrs. mos. 2 hrs. ds.

18. Where was disease contracted if not at place of death? Rexburg Idaho
Did an operation precede death? yes Date of March 13-1929
Was there an autopsy? no
What test confirmed diagnosis? Gen'l symptoms blood urine etc
(Signed) C W Pond, M. D.
March 13, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: SUGAR CITY CEMETERY
Date of Burial: 19
20. Undertaker
Address

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65691

PLACE OF DEATH
County of Bannock
City of POCATELLO, IDAHO

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello Gen. Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5524

2. FULL NAME Anna Laura Benting
(a) Residence. No. POCATELLO, IDAHO St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of C. O. Benting

6. DATE OF BIRTH (month, day and year) Oct 26, 1888

7. AGE Years 40, Months 4 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shoshone Idaho

PARENTS
10. NAME OF FATHER Frank P. Gwin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) California
12. MAIDEN NAME OF MOTHER Anna J. Wallace
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pensylvania

14. Informant C. O. Benting
(Address) POCATELLO, IDAHO

15. Filed Mar 23, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/14, 1929, to 3/22, 1929
that I last saw her alive on 3/22, 1929
and that death occurred, on the date stated above, at 3,30 P. m.
The CAUSE OF DEATH* was as follows:
Intestinal Stasis - following operation for large (11 lbs) tumor of uterus
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) fibro cystic uterus
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Pocatello
Did an operation precede death? Yes Date of 3/18/29
Was there an autopsy? no
What test confirmed diagnosis? usual signs
(Signed) H. C. Irwin, M. D.
Mar 23, 1929 (Address) POCATELLO, IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone, Idaho
Date of Burial: Mar 25 1929

20. Undertaker: McHAN UNDERTAKING CO
Address: POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

HAMNER C. IRWIN, M. D.
CARLSON BUILDING
SUITE 311-12-13-14
POCATELLO, IDAHO

Following operation for fibro-cystic uterine tumor 11 lbs adherent to everything in pelvis. Patient did nicely until afternoon of 21st - Abdomen continued to distended by tympanitic - Kidneys acting well. never any nausea or vomiting - Pulse of good quality - Before oper - Heart & lungs & urine negative B.P. 130/68 - Pulse 90 -

If not case of intestinal stasis don't know cause of death

3/23/29 H. C. Irwin

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 0 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65692

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 3525
(No. 218 N Hayes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Timothy C Quinn

(a) Residence. No. 218 N Hayes St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 3rd 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
	70	1	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Conductor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Patrick Quinn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs T C Quinn
(Address) Pocatello Idaho

15. Filed 3/25, 1929 J H Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 19 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to Mar 19, 1929
that I last saw h— alive on Mar 18, 1929.
and that death occurred, on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis & Broncitis.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) C E Groom M. D.
3/21, 1929. (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	3-22 1929
20. Undertaker	Address
Schumacher & Beasley	Pocatello

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65693

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5526

PLACE OF DEATH

County of Bannock

City of POCATELLO. IDAHO

3-6
-19
-24

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Julia Raynor

(a) Residence. No. 1231 So 1st St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of D. A. Raynor

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Springville Utah

PARENTS

10. NAME OF FATHER George Giles

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Tilern

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant D. A. Raynor

(Address) POCATELLO, IDAHO

15. Filed 3/29, 1929 J. H. Hammond Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH POCATELLO. IDAHO Mar 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-6, 1929, to 3-26, 1929
that I last saw h[illegible] alive on 3-24, 1929
and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:

Cardio-renal

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Focal infection tonsils

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. C. Ray M. D.

, 19 (Address) POCATELLO IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Springville Utah	Mar 30 1929

20. Undertaker McHAN UNDERTAKING CO Address POCATELLO. IDA

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 20 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65694

County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. 143 SOUTH LINCOLN)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5527

2. FULL NAME DONLEY HUNT HARRISON

(a) Residence. No. 143 SOUTH HARRISON St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): SINGLE

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 15, Months 11, Days 13. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: STUDENT
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): POCATELLO

PARENTS

10. NAME OF FATHER: E. LEROY HARRISON
11. BIRTHPLACE OF FATHER (city or town) (State or Country): LOGAN UTAH
12. MAIDEN NAME OF MOTHER: ETHEL WILSON
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): OGDEN UTAH

14. Informant: E. LEROY HARRISON
(Address) 143 SOUTH LINCOLN

15. Filed 4/2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: MARCH 31 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1929, to Mar 31, 1929
that I last saw him alive on March 31, 1929
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Chronic mytral Insufficiency
Myocarditis
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute ascorbosis of the clr terminated by acute sclerosis of heart
Insufficiency (duration) yrs. mos. 30 ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phys. Exam
(Signed) O. F. Coll, M. D.
4/2, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: MOUNTAIN VIEW
Date of Burial: 19

20. Undertaker: A. W. HALL
Address: POCATELLO

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65695

PLACE OF DEATH
County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5528
(No. 221- NORTH MAIN ST.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ALBERT S. HAWKINS

(a) Residence. No. 221- NORTH MAIN St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of MADGE DAVIS

6. DATE OF BIRTH (month, day and year) MAR. 17, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	55	0	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work CONFECTIONER
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) TENN.

PARENTS

10. NAME OF FATHER JOHN HAWKINS
11. BIRTHPLACE OF FATHER (city or town) (State or Country) UNKNOWN
12. MAIDEN NAME OF MOTHER UNKNOWN
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UNKNOWN

14. Informant MRS. ALBERT S. HAWKINS
(Address) 221- NORTH MAIN ST.

15. Filed 4/3, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH APRIL (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to ____, 19__
that I last saw h__ alive on ____, 19__
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
cut his throat and
wrists (Suicidal)
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Arthur W Hall Coroner, M. D.
____, 19__ (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW	APR. 3, 1929
20. Undertaker	**Address**
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65696

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St Anthony Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5529

2. FULL NAME Ruby Simpson
(a) Residence. No. #240 N. Hayes St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) January 10th 1876

7. AGE: ~~53~~ Years 53 Months 2 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mt. Pleasant, Utah

PARENTS
10. NAME OF FATHER Daniel Beckstrom
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Maria Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant Frank H. Pickett
(Address) #240 N. Hayes.

15. Filed 4/4, 1929 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 3rd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20, 1929, to April 3, 1929
that I last saw her alive on April 2nd, 1929
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH was as follows:
Ruth Sefton
Gall Bladder.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C R Chasm, M. D.
4/4, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mt Pleasant Utah — Date of Burial: Apr 5 1929

20. Undertaker: Schumacher & Beasley — Address: Cary

Roy

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65697

Local Registrar's No. 5530

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

(No. N. of City)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Flavio Dominguez

(a) Residence. No. N. of City St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Spanish

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years: 35 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Colorado

PARENTS

10. NAME OF FATHER: Leandro Gonzales

11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Rosa Dominguez

(Address) Pocatello Idaho

15. Filed 4/4, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30, 1929, to apr 2, 1929

that I last saw her alive on 2 1 2, 1929

and that death occurred, on the date stated above, at 11,10 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D C Ray, M. D.

4-3, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: April 4 1929

20. Undertaker: Schumacher & Beasley — Address: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65698

Local Registrar's No. 5531

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. 404 So 6th)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant John Pattis

(a) Residence. No. 404 So 6th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
			1	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS

10. NAME OF FATHER John Pattis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Texas
12. MAIDEN NAME OF MOTHER Penley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Mrs Pattis
(Address) Pocatello

15. Filed 4/4, 1929 J. M. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 27, 1929 to Mch 28 1929
that I last saw him alive on Mch 28, 1929
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:
Premature birth
Ruptured Compensation Valvular
Heart disease of mother
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis
(Signed) Elmer William J. Howard M. D.
Apr. 4, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt View — Date of Burial 3-28 1929

20. Undertaker Schumacher & Beasley — Address Pocatello

Irwin

PLACE OF DEATH
RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65699

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5532
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Lottie Cannon

(a) Residence. No. — St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 22-1872

7. AGE — Years: 56 | Months: 5 | Days: 10 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Maryland

PARENTS
10. NAME OF FATHER: John Cuthank
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Margaret Leison
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New York

14. Informant: Charles Cannon
(Address): Pocatello Idaho

15. Filed 4/5, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/1, 1929, to 4/2, 1929
that I last saw her alive on 4/2, 1929
and that death occurred, on the date stated above, at 1100 m.

The CAUSE OF DEATH* was as follows:
Ruptured appendix —
General peritonitis
Toxaemia
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Ruptured Appendix
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Pocatello
Did an operation precede death? Yes Date of 4/1/29
Was there an autopsy? No
What test confirmed diagnosis? Usual
(Signed) H. C. Irwin, M. D.
4/4, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: April 4 1929
20. Undertaker: Schumacher & Moody — Address: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65700

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Poc. General Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number)

Local Registrar's No. 5533

2. FULL NAME William Oliver Deaton
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced
5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~
6. DATE OF BIRTH (month, day and year): May 9. 1872
7. AGE: 56 Years, 10 Months, 28 Days. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Watchmen
(b) General nature of industry, business, or establishment in which employed (or employer): O. S. L. R. R. Co
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS
10. NAME OF FATHER: P. G. Deaton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina
12. MAIDEN NAME OF MOTHER: Martha Burrus
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): North Carolina

14. Informant: Raymond C. Deaton
(Address) 1229 N. Hayes. Pocatello
15. Filed Apr 5, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 4-2, 1929, to 4-5, 1929
that I last saw him alive on 4-5, 1929
and that death occurred, on the date stated above, at 10 45 a. m.
The CAUSE OF DEATH* was as follows:
Uremia
..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary): Chr. nephritis
..... (duration) ..... yrs. 6 mos. ..... ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) E. [signature] M. D.
April 5, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Idaho — Date of Burial: Apr 7 1929
20. Undertaker: McHan Undt Co. — Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65701

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 216
Local Registrar's No. 5534
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Josephine Girard

(a) Residence. No. Mackay Idaho St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1887

7. AGE: Years 42 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) France

PARENTS

10. NAME OF FATHER Bechet
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Louis Girard
(Address) Mackay Idaho

15. Filed 4/7, 1929 J. F. James Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: apr (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from apr 1, 1929, to apr 7, 1929
that I last saw her alive on apr 7, 1929
and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:
Oper. for fibroid uterus
Pulmonary embolism
Intestinal Stasis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Embolism
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Pocatello
Did an operation precede death? Yes Date of 4/4/29
Was there an autopsy? No
What test confirmed diagnosis? Usual
(Signed) H. C. Squire, M. D.
4/7, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mackay Idaho | Date of Burial: Apr 8 1929
20. Undertaker: Schumacher & Hawley | Address: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 20 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65702

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5535

(No. 1205 So. 3rd ave.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carline Williams

(a) Residence. No. 1205 So. 3rd St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long i[illegible]S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Chas J. Williams

6. DATE OF BIRTH (month, day and year) Oct 15-1892

7. AGE Years 37 Months 5 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER Beaumont

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Chas J. Williams
(Address) Pocatello, Idaho

15. Filed Apr 9, 1929 J. Young Registrar

[illegible]EDICAL CERTIFICATE OF DEATH

16. DATE [illegible] DEATH April 7 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1928, to Apr 7, 1929

that I last saw h..... alive on July, 19..

and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

Heart block

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) D. C. Ray M. D.

April 9, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Ida

Date of Burial: April 9 1929

20. Undertaker: McHan Undt Co

Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65703

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. 823 SOUTH FORTH AVE.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5536

2. FULL NAME MARY E. HENDERSON
(a) Residence. No. 823 SOUTH FORTH AVE St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): MARRIED

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of HENRY W HENDERSON

6. DATE OF BIRTH (month, day and year) DEC. 20 1876

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
52	3	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work AT HOME
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) FARMINGTON UTAH.

PARENTS

10. NAME OF FATHER JOHN TIPPETS
11. BIRTHPLACE OF FATHER (city or town) (State or Country) VERMONT
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ENGLAND

14. Informant HENRY W. HENDERSON
(Address) 823 SOUTH. FORTH

15. Filed 4/10, 1929. J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH APRIL, (Month) 8th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11, 19__, to April 11, 1929
that I last saw her alive on April 1, 1929
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows: Pulmonary Embolism
Sudden
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cholycystectomy for gall
Stones 3/18/29
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? Yes Date of 3/18/29
Was there an autopsy?
What test confirmed diagnosis?
(Signed) O. R. Hall, M. D.
4/10, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: MOUNTAIN VIEW, CEM. Date of Burial: APRIL, 1929

20. Undertaker: ARTHUR W. HALL Address: POCATELLO

RECEIVED APR 20 1929

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65704

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5537

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME A. Clay

(a) Residence. No. — St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE: about 60 Years | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: laborer
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS
10. NAME OF FATHER: "
11. BIRTHPLACE OF FATHER (city or town) (State or Country): " "
12. MAIDEN NAME OF MOTHER: "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Police Dept
(Address): Pocatello, Idaho

15. Filed Apr 12, 1929 J. Hanney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/9, 1929, to 4-12, 1929
that I last saw him alive on 4-12, 1929
and that death occurred, on the date stated above, at 2 A. m.
The CAUSE OF DEATH* was as follows:
Cardio Renal disease
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. Hanney, M. D.
4/12, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Ida. | Date of Burial: April 13 1929

20. Undertaker: McHan Undt Co. | Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65705

PLACE OF DEATH
County of ~~Franklin~~ Bannock
City of Oxford
Registration District No. 8 9
Primary Registration District No. 2160
Local Registrar's No. 107
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louise Kensie

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Female~~
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 8 1928

7. AGE — Years: — Months: 1 10 — Days: — If LESS than 1 day, hrs. or min.:

8. OCCUPATION OF DECEASED: baby
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Oxford

PARENTS

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown Kensie California

12. MAIDEN NAME OF MOTHER: Jennie Kendall

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Downey Idaho

14. Informant: Chas Kendall
(Address): Oxford Idaho

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18, 1929, to Feb 18, 1929
that I last saw her alive on Feb 18, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Congenital heart disease —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? —
What test confirmed diagnosis? Clinical

(Signed) H. W. Slates, M. D.
Feb 19, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Oxford Idaho	Feb 20 29 19
20. Undertaker	Address

RECEIVED APR 12 1929

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Downey Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38

Primary Registration District No. 2160

(No. ..... St.)

File No. 65706

Registered No. 106

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Otto Grant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Mar. (Month) 28 (Day) 1915 (Year)

7. AGE: 13 Yrs. 11 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Business Man's

(b) General nature of industry, business or establishment in which employed (or employer): Son

9. BIRTHPLACE (State or Country): Chester Field Ida Bannock County

10. NAME OF FATHER: John I Grant

11. BIRTHPLACE OF FATHER (State or Country): Chester Field Ida Bannock County

12. MAIDEN NAME OF MOTHER: Myrtle Hogan

13. BIRTHPLACE OF MOTHER (State or Country): Hatch Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Myrtle Spidell

(Address) Downey Ida.

15. Filed Mar. 20 1929 Mary E. Coffin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) - 2 (Day) - 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan - 26 - 1929, to Mar - 2 - 1929 that I last saw him alive on Mar - 2 - 1929 and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows: Rheumatic Endocarditis.

(Duration) ..... Yrs. 1 mos. 7 ds.

Contributory (Secondary): Lobar Pneumonia.

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) H. J. Hartigan, M. D.

3-3-1929 (Address) Downey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chester Field Id.

DATE OF BURIAL: Mar 5 1929

20. UNDERTAKER: M W Hendricks

ADDRESS: Preston

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65707

Local Registrar's No. 148

PLACE OF DEATH

County of Bannock
City of Bancroft
Registration District No. 84
Primary Registration District No. 2161
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Monroe White

(a) Residence. No. Bancroft St. Ida
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 27-1910

7. AGE: Years 18 | Months 10 | Days 22 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bancroft Ida

PARENTS

10. NAME OF FATHER: J. Monroe White
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kansas
12. MAIDEN NAME OF MOTHER: Daisy Lay Lewis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Riverdale Idaho

14. Informant: L. E. Burdon
(Address): Bancroft Ida

15. Filed 3-21-1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from about 6 year, 19 , to May-20, 1929
that I last saw him alive on March 20, 1929
and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:
Chronic dilatation of the heart caused by attack of measles about 10 years ago.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. J. Fetz, M. D.
3-21-, 1929 (Address) Bancroft Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Soda Springs Ida — Date of Burial: 3-23-1929

20. Undertaker: O. D. Whitman — Address: Soda Springs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 84

DO NOT WRITE IN THIS SPACE
State File No. 65708

Local Registrar's No. 149

PLACE OF DEATH
County of Bannock Registration District No.
City of Grace Primary Registration District No. 2161
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Baby Frank Miles

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 3-27-29

7 AGE	Years	Months	Days	If LESS than 1 day: hrs. or min.
				30 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Grace Ida

PARENTS
10 NAME OF FATHER Frank Miles
11 BIRTHPLACE OF FATHER (city or town) (State or country) Soda Spgs. Ida.
12 MAIDEN NAME OF MOTHER Caroline Belinthia Bybee
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Grace Ida.

14 Informant Father
(Address)

15 Filed Apr. 30, 1929 Mrs. G. G. Fitt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 27 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 27, 1929, to Mar 27, 1929,
that I last saw h alive on Mar 27, 1929
and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:
Primary respira-
tory asthenia.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Difficult birth
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) G. E. Fitt M. D.
3-27, 1929 (Address) Grace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65709

PLACE OF DEATH
County of Bannock. Registration District No. 84
City of McCammon Primary Registration District No. 2161 Local Registrar's No. 150
(No. Municipal Sanitarium Lava Hot Springs.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elwin Ferrald Hall.
(a) Residence. No. McCammon Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. 8 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: None
6. DATE OF BIRTH (month, day and year): July 15 1913.
7. AGE — Years: 15 Months: 8 Days: 12. If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School boy.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: None
9. BIRTHPLACE (city or town) (State or country): McCammon.

PARENTS
10. NAME OF FATHER: Elwin Hall.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Portage Utah.
12. MAIDEN NAME OF MOTHER: Lucy Ora Southworth
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Montpelier Idaho.

14. Informant
(Address) Elwin Hall McCammon

15. Filed 4-30, 1929 Mrs. G. G. F. Idaho
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 27 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar. 23, 1929, to Mar 27, 1929
that I last saw him alive on Mar 27, 1929
and that death occurred, on the date stated above, at 8 00 A. m.
The CAUSE OF DEATH* was as follows:
Cerebro spinal Mengitis
Epidemic in form
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary): None
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? At McCammon
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Laborotory findings
(Signed) C A Rich M. D.
3-27, 1929 (Address) Lava Hot Spgs.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19
20. Undertaker | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19. RECEIVED MAY 1 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 65710
Registered No. 157

1. PLACE OF DEATH
County of Bannock
Registration District No. 84
Primary Registration District No. 2161
City of Lava Hot Springs (If outside limits, give township) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Piedmont
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 11 (Day) 1917 (Year)

7. AGE: 10 Yrs. 4 Mos. 17 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kemmer Wyo.

10. NAME OF FATHER: Joe Piedmont

11. BIRTHPLACE OF FATHER (State or Country): Gospich Jugoslavia

12. MAIDEN NAME OF MOTHER: Katherine Tomich

13. BIRTHPLACE OF MOTHER (State or Country): Gospich Jugoslavia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Piedmont By C.A.R.
(Address) Lava Hot Springs

15. Filed Apr. 30 1929 Mrs. G. G. Fitz
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1929 to March 28 1929 that I last saw her alive on March 28 1929, and that death occurred on the date stated above, at 8:55 P.M.
The CAUSE OF DEATH* was as follows:
Peritonitis
(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Intestinal influenza
(Duration) yrs. mos. 6 ds.
(Signed) C. A. Rich M. D.
3-28-1929 (Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 4 days. In the State 8 yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19

RECEIVED MAY 4 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 84

County of Bannock · Primary Registration District No. 2161

File No. 65711

City of Lava Hot Springs (No. ....., ... St.)

Registered No. 132

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Joseph Brower

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March (Month) 29 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Lava Hot Springs Idaho

10. NAME OF FATHER: Joseph Lloyd Brower

11. BIRTHPLACE OF FATHER (State or Country): Idaho Falls.

12. MAIDEN NAME OF MOTHER: Hanna Blair

13. BIRTHPLACE OF MOTHER (State or Country): Garfield, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. L. Brower

(Address) Lava Hot Springs.

15. Filed Apr. 30 1929 Mrs. G G Fitz
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 29 1929, to Mar 29 1929 that I last saw him alive on Mar 29 1929 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) 6 mos Pregnancy

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Rucks M. D.

3-29 1929 (Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lava Hot Springs — DATE OF BURIAL: Mar 29 1929

20. UNDERTAKER: None — ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65712

PLACE OF DEATH
County of Bear Lake
City of St Charles

Registration District No. 58
Primary Registration District No. 2-134
(No. .....)
Local Registrar's No. 5
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Willelmina W. Brewer

(a) Residence. No. St Charles — Idaho St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. 65 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.
(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Charles H Brewer

6. DATE OF BIRTH (month, day and year) Feb 6th 1855

7. AGE	Years	Months	Days	If LESS than 1 day,
	74	1	25	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Copenhagen - Denmark
(State or country)

PARENTS

10. NAME OF FATHER Niels Wilhelmsen
11. BIRTHPLACE OF FATHER (city or town) Copenhagen
(State or Country) Denmark
12. MAIDEN NAME OF MOTHER ~~Olsen~~ Annie Christina Nielsen
13. BIRTHPLACE OF MOTHER (city or town) Copenhagen
(State or Country) Denmark

14. Informant C. H. Brewer
(Address) 1171 Yale Ave Salt Lake City

15. Filed April 4, 1929 Hannah J. Nelson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 1
(Month) Mar (Day) 31 (Year) 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 30, 1929, to Mar 31, 1929
that I last saw her alive on Mar 31, 1929
and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:
Apoplexy, Cerebral
(duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Exposure
(duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) C O Meeks, M. D.
4/1, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Charles - Idaho	Apr 4 1929
20. Undertaker E. W. Allred	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 10 1929

PLACE OF DEATH

County of Benewah

City of St Maries

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 3r

Primary Registration District No. 20x9

DO NOT WRITE IN THIS SPACE

State File No. 65713

Local Registrar's No. 8

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Tom Scullin

(a) Residence. No. 1689 Jefferson Ave, St Paul Minn (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Thomas Scullin

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer) Weiden Lumber Co.

(c) Name of employer "

9. BIRTHPLACE (city or town) (State or country) ?

PARENTS

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ?

14. Informant St Maries Hosp. record

(Address) St Maries Idaho

15. Filed Apr. 12, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 5, 1929, to Apr 11, 1929

that I last saw him alive on Apr 11, 1929

and that death occurred, on the date stated above, at 11 12 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Influenza ?

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At camp

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C A Cobun, M. D.

Apr 11, 1929 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of ~~Burial~~ Approx
Stillwater Minn	Apr. 12 1929

20. Undertaker Mitchell & Meagher Address St Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

PLACE OF DEATH

County of Bennah

City of St Maries

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 65714

Local Registrar's No. 9

2. FULL NAME Ramon Elmer Scheuerman

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6. DATE OF BIRTH (month, day and year) June 9 - 1927

7. AGE: Years 1, Months 9, Days 25. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): St Maries Ida

PARENTS

10. NAME OF FATHER: Philip Scheuerman

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Anna Marie Hergert

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14. Informant: Mr. Philip Scheuerman
(Address) St Maries Ida

15. Filed Apr 5, 1929 O. Meraque Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 31, 1929, to April 4, 1929

that I last saw him alive on April 4, 1929

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows: meningitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Flu

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) G G Estes, M. D.

4/8, 1929 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Woodlawn — Date of Burial: Apr 6 1929

20. Undertaker: Mitchell & Meraque — Address: St Maries Ida

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65715

PLACE OF DEATH
County of Bennah
City of Alder Creek
Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 10
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Henry Vroman

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 19-1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	0	24	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher & Fire Warden
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) New York State
(State or country)

PARENTS

10. NAME OF FATHER Henry Vroman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Mary Stacy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Holland

14. Informant Mrs. Thomas H. Vroman
(Address) Alder Creek Idaho

15. Filed Apr. 16, 1929 O Greenough Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 13 1929, to ....., 19.....
that I last saw him ~~alive~~ died on Apr 14, 1929
and that death occurred, on the date stated above, at A m.
The CAUSE OF DEATH* was as follows:

Cancer of Rectum

..... (duration) ..... yrs. ..... mos. ..... ds.
Chronic Nephritis
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of .....
Was there an autopsy? examination
What test confirmed diagnosis? .....
(Signed) O Greenough Coroner, M. D.
Apr 14, 1929 (Address) St Mary Idaho Bennah Co

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Woodlawn	Apr 16 1929
20. Undertaker	Address
Mitchell & Meagher	St Mary Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65716

PLACE OF DEATH
County of Benewah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

2. FULL NAME Cora May Nichols.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 8 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Willis Edgar Nichols.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
Fifty Five	Seven	Fifteen	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer) housewife
(c) Name of employer

9. BIRTHPLACE (city or town) Michigan.
(State or country)

PARENTS

10. NAME OF FATHER Bergamont Briggs.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Willis E Nichols
(Address) St Maries Ida

15. Filed Apr 18, 1929 O Illegible Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6, 1929, to Apr 17, 1929
that I last saw h er alive on Apr 15, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) Unknown yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Toxic thyroid - Nephritis
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) Carl Illegible M. D.
4/19, 1929 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Woodlawn	Apr 19 1929
20. Undertaker	Address
Mitchell & Illegible	St Maries Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65717

PLACE OF DEATH
County of Benewah
City of Benewah P. O.

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 12

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Claude Paullus Jr.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6. DATE OF BIRTH (month, day and year): Nov 8 - 1927

7. AGE: Years 1, Months 5, Days 13. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Tekoa Wash

PARENTS

10. NAME OF FATHER: Claude Paullus
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pullman Wash
12. MAIDEN NAME OF MOTHER: Ethel Saunders
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Peck Idaho

14. Informant: Claude Paullus
(Address): Benewah Route

15. Filed Apr. 21, 1929 O. Meerager Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/21, 1929, to 4/21, 1929
that I last saw him alive on 4/21, 1929
and that death occurred, on the date stated above, at 5:30 A m.
The CAUSE OF DEATH* was as follows:
Menengitis
Epidemic Type
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G. G. Espe, M. D.
Apr. 22, 1929 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Woodlawn
Date of Burial: Apr. 24 1929

20. Undertaker: Mitchell & Meager
Address: St Maries Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. RECEIVED MAY 10 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 65718

Registered No. 13

1. PLACE OF DEATH.

County of Benewah

City of St Maries, Ida

Registration District No. 32

Primary Registration District No. 2049

(No. St Maries Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vernon C. Armstrong

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Jan (Month) 25 (Day) 1920 (Year)

7. AGE 9 Yrs. 3 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER V. E. Armstrong

11. BIRTHPLACE OF FATHER (State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Ethel Smith

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C A Robins
(Address) St Maries, Ida

15. Filed Apr. 27 1928 O. Meraque Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 25 1929, to Apr 26 1929, that I last saw him alive on Apr 26 1929, and that death occured on the date stated above, at 2:10 A M.

The CAUSE OF DEATH* was as follows:
Struck by automobile.
Accidental.

(Duration) 1 Yrs. mos. 1 ds.

Contributory (Secondary) Shock.

(Duration) yrs. mos. 1 ds.

(Signed) C A Robins M. D.

4/26 1929 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos...1..days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Woodlawn

DATE OF BURIAL Apr 28 1929

20. UNDERTAKER Mitchell & Meraque

ADDRESS St Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAY 8 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah

City of De Smet

Registration District No. 31

Primary Registration District No.

(No. ....., ... St.)

File No. 65719

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amelia Leo.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. June (Month) 16 (Day) 1916 (Year)

7. AGE 12 Yrs. 3 Mos. 22 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) C D'A Reservation Idaho

10. NAME OF FATHER Victor Leo.

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Treasa Joseph.

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Victor Leo

(Address) Tekoa, Wash

15. Filed April 10, 1929 John Post Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 8 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1929, to Apr 8 1929, that I last saw her alive on March 15 1929, and that death occured on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration 1 yrs. 6 mos. ..... ds.

(Signed) Dr C B Cleiger M. D.

4-9 1929 (Address) Tekoa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL De Smet Idaho

DATE OF BURIAL Apr. 10 1929

20. UNDERTAKER C. L. Schulerud

ADDRESS Tekoa, Wash.

SYMS - YORK CO., PTRS. & BORS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 65720
Registered No. 2

1. PLACE OF DEATH

County of Benewah RECEIVED MAY 8 1929

City of Peda station

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caryl Sarah Stratten

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. ~~SINGLE~~, MARRIED, WIDOWED OR DIVORCED. Married (~~Write the word~~)

6. DATE OF BIRTH. July (Month) 11 (Day) 1901 (Year)

7. AGE 27 Yrs. 9 Mos. 13 ds.

IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Formerly school teacher

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER Tomas J. Campbell

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Eunice F. Wagar

13. BIRTHPLACE OF MOTHER (State or Country) Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence A. Stratten
(Address) Plummer, Ida

15. Filed Apr. 26 1929 H. Jaeger Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Not seen until after 191 ... 191 ... that I last saw ... alive on ... 191 ... and that death occurred on the date stated above, at 6:25 A M.

The CAUSE OF DEATH* was as follows:
Heart failure.
"I never saw this lady after death"

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Congenital Weakness.

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. J. Henington M. D.

4/26 1929 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~ Plummer, Ida. DATE OF BURIAL 4-26 1929

20. UNDERTAKER H. G. Jaeger ADDRESS Plummer

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65721

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 63.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lyle Raymond Sullivan

(a) Residence. No. Shelley Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 17-28

7. AGE Years | Months 8 | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: no.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Shelley Ida

PARENTS

10. NAME OF FATHER: Arthur Sullivan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill
12. MAIDEN NAME OF MOTHER: Rose Malony
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa.

14. Informant: Arthur Sullivan
(Address)

15. Filed April 5, 1929 Mrs Clara E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 31st, 1929, to Apr 1st, 1929
that I last saw him alive on Apr. 1st, 1929
and that death occurred, on the date stated above, at 9 23 a m.
The CAUSE OF DEATH* was as follows: Ilio-coecal Intussusception

..... (duration) ..... yrs. ..... mos. 12 hrs.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) + [signature], M. D.
Apr. 3, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida | Date of Burial: Apr. 3 1929

20. Undertaker: Jeff C Hayes | Address: Idaho Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65722

PLACE OF DEATH
County of Bingham
City of Goshen

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 64

2. FULL NAME Niels Monson
(a) Residence. No. Goshen, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 36 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Amelia Monson

6. DATE OF BIRTH (month, day and year)

7. AGE 78 Years | Months 1 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kaser, Denmark

PARENTS

10. NAME OF FATHER: Hans Monson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Martha Jensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Willard Monson
(Address): Goshen Idaho

15. Filed April 8, 1929 Mrs Walter E Fabrill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 1st, 1929, to Apr 3, 1929
that I last ~~saw~~ alive on Apr 2nd, 1929
and that death occurred, on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Cancer of Liver
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Acites
(duration) ..... yrs. 3 mos. 5 days ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? [illegible]
(Signed) F. G. Cheney, M. D.
Apr 6, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hyrum Utah | Date of Burial: Apr 9 1929

20. Undertaker: Cliff Hayes | Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65723

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 65
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard Wayne Rogers
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Infant
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓
6. DATE OF BIRTH (month, day and year) Mch. 9th 29
7. AGE Years | Months | Days 27 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓
9. BIRTHPLACE (city or town) (State or country) Downey Idaho

PARENTS
10. NAME OF FATHER Alman C. Rogers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Eaton Colo
12. MAIDEN NAME OF MOTHER Vivian Day
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Richmond Wash

14. Informant Mrs R. N. Brewington
(Address) Firth Idaho
15. Filed April 8, 1929 Mr Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 4th (Day) 29 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr. 3, 1929 to Apr. 4, 1929
that I last saw him alive on Apr 3, 1929
and that death occurred, on the date stated above, at 10:45 a.m.
The CAUSE OF DEATH* was as follows: No diagnosis made - Very large liver, extreme jaundice. All life - Probably congenital obstruction of bile passages
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) F. W. Roberts, M. D.
Apr. 6th, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Firth, Idaho | Date of Burial Apr 8 - 1929
20. Undertaker Almar C. Rogers | Address Shelley

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65724

Local Registrar's No. 66

PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2194
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Rasmussen
(a) Residence. No. Blackfoot RFD #2 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 16th 1867

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	4	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Robert Rasmussen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Dent Knud
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Fred R. Rasmussen
(Address)

15. Filed Apr 5, 1929 McClellan & Fabian Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 4, 1929 to April 4, 1929
that I last saw ~~him~~ alive on April 4, 1929
and that death occurred, on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:

Sarcoma of Liver
(duration) yrs. 4 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. McClellan, M. D.
April 5, 1929 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Groveland Cemetery	April 6 1929
20. Undertaker	Address
E. T. Tuckett	Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65725

PLACE OF DEATH
County of Bingham
City of Woodville

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 67

2. FULL NAME Gladys Mabel Risenmay
(a) Residence. No. ..... St. Woodville, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 7, 1892

7. AGE: Years 37, Months 4, Days 28. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hyrum, Utah

PARENTS
10. NAME OF FATHER: H. B. Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Helen Christensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: George Risenmay
(Address) Woodville, Idaho

15. Filed: June 17, 1929 Mr. Walter E. Stirling Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1926 to 4-5-, 1929
that I last saw her alive on 4-5-, 1929
and that death occurred, on the date stated above, at 4-15a m.
The CAUSE OF DEATH* was as follows:
Acute dilation of the heart.
..... (duration) ..... yrs. ..... mos. 4 hrs. ds.
CONTRIBUTORY (Secondary): Chronic Endocarditis, Pregnancy + parturition
..... (duration) ..... yrs. ..... mos. 5 hrs. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Edwin Cutler, M. D.
4/14, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Woodville, Idaho
Date of Burial: April 7 1929

20. Undertaker: Jack G. Wood
Address: Idaho Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65726

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 68

2. FULL NAME Gladys Joan Peterson (Peterson)

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb 24th 1928

7. AGE: Years 1, Months 1, Days 14. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Blackfoot Idaho

PARENTS

10. NAME OF FATHER: J W Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Plain City Utah
12. MAIDEN NAME OF MOTHER: Sarah Palmer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland Idaho

14. Informant: J W Peterson
(Address): Blackfoot

15. Filed: Apr. 7, 1929 Mrs Valerie E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Mch~~ April (Month) 6th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12, 1929, to Mch 6, 1929 that I last saw her alive on Mch 6, 1929 and that death occurred, on the date stated above, at 7:45 p.m.

The CAUSE OF DEATH* was as follows:
Influenza
..... (duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary): Bronchio pneumonia
..... (duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? X
Did an operation precede death? no Date of X
Was there an autopsy? no
What test confirmed diagnosis? Clinical Indices
(Signed) J. O. Hampton M. D.
3-7, 1929 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Thomas Riverside — Date of Burial: Apr 8 1929

20. Undertaker: E J Frank — Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65727

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 69

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leola N. Stewart
(a) Residence. No. Woodville Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) June 4th 1927

7. AGE Years 1 Months 10 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Woodville Ida

PARENTS
10. NAME OF FATHER Clifton B. Stewart
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cricleville Utah
12. MAIDEN NAME OF MOTHER Nora Pugh
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Carol Va

14. Informant Clifton B. Stewart
(Address) Shelley Route #3, X

15. Filed April 17, 1929 Mrs Walter E. Fielding Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1st, 1929, to Apr. 8, 1929
that I last saw her alive on Apr. 7, 1929
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:
Mastoiditis
..... (duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) T. V. Roberts, M. D.
Apr. 9, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Woodville Idaho
Date of Burial Apr 10 - 1929

20. Undertaker Clifton B. Stewart
Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65728

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 124
Primary Registration District No. 2194
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 70

2. FULL NAME Conrad J. Bair

(a) Residence. No. Shelley Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Mar

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 6 1923

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	0	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley Idaho

PARENTS

10. NAME OF FATHER J. L. Bair
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Richmond Utah
12. MAIDEN NAME OF MOTHER Ethel Buxton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Richmond Utah

14. Informant F. J. Bair
(Address) Shelley Idaho

15. Filed June 17, 1924 W. McClellan State Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 4, 1929, to Apr 8, 1929, that I last saw h[illegible] alive on Apr 8 1929 and that death occurred, on the date stated above, at 2 15 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar
(duration) 7 yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Heart Failure
(duration) yrs. mos. hrs. ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J. W. McClellan, M. D.
Apr 9, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Richmond, Utah	April 11—1929
20. Undertaker	Address
Alma Jackman	Richmond, Utah

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65729

PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 1007
Local Registrar's No. 71
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Estella McDiarmid=Deal (Estella Mc. Diarmid Deal)

(a) Residence. No. 156 So. University St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of C. E. Deal

6. DATE OF BIRTH (month, day and year) Nov. 6, 1870

7. AGE	Years	Months	Days	If LESS than 1 day,
	58	6	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home-wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Bonne Ch.
(State or country) Michigan

PARENTS

10. NAME OF FATHER Angus McDiarmid
11. BIRTHPLACE OF FATHER (city or town) Bonne Ch.
(State or Country) Michigan
12. MAIDEN NAME OF MOTHER Emma McDatt
13. BIRTHPLACE OF MOTHER (city or town) Bonne Ch.
(State or Country) Michigan

14. Informant C. E. Deal
(Address) Blackfoot, Idaho

15. Filed Apr 9, 1929 W. Wales State Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 8, 1929, to Apr 8, 1929 that I last saw her alive on Was dead when I arrived and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Sudden Heart failure
(duration) few min. ds.
CONTRIBUTORY (Secondary) Angina Pectoris
(duration) 4 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. W. Beck M. D.
4/9, 1929 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Filer, Idaho	19
20. Undertaker	Address
C. F. Peck	Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED MAY 10 1929

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65730

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. I2I
Primary Registration District No. I007
(No. County Hospital Mrs Dora France)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 72

2. FULL NAME Julia Littlefield.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. I9, I928

7 AGE Years | Months 3 | Days 2I | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Bingham Co. Idaho

PARENTS
10 NAME OF FATHER David W. Littlefield
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ogden, Utah
12 MAIDEN NAME OF MOTHER Goldie Pepper
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Payson, Utah

14 Informant Goldie Pepper Littlefield.
(Address) 74 S.E. Main St. Blackfoot, Idaho.

15 Filed April IO 19 29 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April IO. I929 19..... (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 3, 19 29, to Apr. IO., 19....., that I last saw her alive on Apr. 7, I92, 19....., and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Premature 8 mo. in utero
Indigestion and artificial
feeding. (duration) ..... yrs. 3 mos. 2I ds.

CONTRIBUTORY (Secondary) Defective-conjenita l
..... (duration) ..... yrs. 3 mos. 2I ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) [signature], M. D.
Apr. IO, 19 29 County Physician (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: G. C. Cem. Blackfoot, Ida.
Date of Burial: Apr 11 1929

20 Undertaker: C. T. Peck
Address: B

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65731

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 73

PLACE OF DEATH
County of Bingham
City of Shelley
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Tadamson
(a) Residence. No. Shelley, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs James Adamson

6. DATE OF BIRTH (month, day and year) February 11, 1868

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	2	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) American Fork Utah

PARENTS
10. NAME OF FATHER James Adamson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Martha Cuff Cook
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs James Adamson
(Address) Shelley, Idaho

15. Filed April 17 1929 Claire E. Potter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-10- 1929 to 4-11- 1929
that I last saw h~~e~~r alive on 4-10- 1929
and that death occurred, on the date stated above, at 2:30 a.m.
The CAUSE OF DEATH* was as follows: Arteria Sclerosis

(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Angina Pectoris
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? c none
(Signed) Edwin Cutler, M. D.
4/14 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shelley Idaho	April 14 1929
20. Undertaker J. A. Wood	Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

PLACE OF DEATH

County of Bingham

City of Blackfoot

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65732

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 74

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rebecca Jane Martin (Martin.)

(a) Residence. No. 767 East Judicine St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 16 1853

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
76	1	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Webster N. C.

PARENTS

10. NAME OF FATHER A. B. Bumgarner

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. C.

12. MAIDEN NAME OF MOTHER Matilda Fischer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. C.

14. Informant Edna Gillespie

(Address) 3 Colora Apartments

15. Filed Apr. 13, 1929 Mrs Charles E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2, 1928, to April 13, 1929

that I last saw her alive on April 12, 1929

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver & Stomach

..... (duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical finding

(Signed) A. O. Hampton M. D.

4-13, 1929 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Green city cemetery

Date of Burial: April 16 1929

20. Undertaker: E. J. Peck

Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65733

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 75

2. FULL NAME Joseph Milton Parsons
(a) Residence. No. Sterling Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 15 1912

7. AGE Years 16 Months 11 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work in school
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Aberdeen ~~Id~~ Idaho

PARENTS

10. NAME OF FATHER Geo W Parson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bingham City Idaho
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rose A Cornford England

14. Informant D. L. Parsons
(Address) Sterling Idaho

15. Filed Apr. 17, 1929 Mrs Walter E Vatter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1929, to April 16, 1929
that I last saw him alive on April 16, 1929
and that death occurred, on the date stated above, at 2. P m.
The CAUSE OF DEATH* was as follows:
Concussion of Brain
..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Struck with Base Ball Accidental
..... (duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) F. Mitchell, M. D.
4/16, 1929 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sterling Idaho — Date of Burial April 18 1929

20. Undertaker E. F. Peck — Address Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65734

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 76

2. FULL NAME EZRA BUTLER

(a) Residence. No. ..... St. Idaho Falls Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 57 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hooper, Utah

PARENTS

10. NAME OF FATHER: Alma Butler
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: ooo-
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Fred Hayes Att.
(Address) Blackfoot Idaho

15. Filed April 22 1929 McClaren E. Tabue Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 20th, 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1927, 19 ..., to Apr 20th-1929, 19 ...
that I last saw him alive on Apr. 20th, 1929, 19 ...
and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No

(Signed) G. E. Williams M. D.
Apr. 20th 1929, 19 ... (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Asylum Cem. | Date of Burial 19

20. Undertaker: J. A. Bailey | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65735

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 77

(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jose ROMO

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE

4. COLOR OR RACE: MEXICAN

5. Single, Married, Widowed, or Divorced (write the word): Unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept 1897

7. AGE: 31 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ---

(c) Name of employer: ---

9. BIRTHPLACE (city or town) (State or country): Mexico

PARENTS

10. NAME OF FATHER: ---

11. BIRTHPLACE OF FATHER (city or town) (State or Country): ---

12. MAIDEN NAME OF MOTHER: ---

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ---

14. Informant: D. E. Wilson Att.
(Address) Blackfoot, Idaho.

15. Filed April 22, 1929 Mrs Walter E Fabric Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. 21st, 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 29th-1929, 19 to Apr 21st 1929, 19

that I last saw him alive on Apr 21st 1929, 19

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? Dont know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood test (Wass) 4+

(Signed) Geo Williams M. D.

Apr. 22nd, 1929 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Asylum Cem. | Date of Burial 19

20. Undertaker: J. A. Bailey | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 10 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65736

County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 78
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clara Jane Dockery

(a) Residence. No. ..... Ringo Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of C E. Dockery

6. DATE OF BIRTH (month, day and year) Jan 13-1877

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	3	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Indiana Penn.

PARENTS

10. NAME OF FATHER Ruben L Rees
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Lara Meyers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant George A Reece
(Address) Ringo Idaho

15. Filed Apr. 29, 1929 Mc Caleb E Waters Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1928, to April 27, 1929
that I last saw h.r alive on March 31, 1929
and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis with Hypertension and general Anasarca
(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) J O Humphreys M. D.
4-29, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Shelley Idaho	
20. Undertaker E J Peck	Address Blackfoot Ida

RECEIVED MAY 10 1929

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65737

Registration District No. 1 27

Primary Registration District No. 2194

Local Registrar's No. 79

(No. SOUTH IDAHO INSANE ASYLUM)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME WILLIAM T CORDINGLY

(a) Residence. No. ..... St. PRESTON
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE

4. COLOR OR RACE WHITE

5. Single, Married, Widowed, or Divorced (write the word) SINGLE

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 75 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ---

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ---

PARENTS

10. NAME OF FATHER ---

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ---

12. MAIDEN NAME OF MOTHER ---

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ---

14. Informant A. G. Mercer Att.
(Address) Blackfoot, Idaho.

15. Filed May 24, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 30th, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 27th-1929, 19..., to Apr 30-1929, 19...

that I last saw him alive on Apr 30th 1929, 19...

and that death occurred, on the date stated above, at 5:30P m.

The CAUSE OF DEATH* was as follows:

Gen. Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) SENILE DEMENTIA

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Geo. Williams, M. D.

Apr 30th 1929, 19... (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashton Idaho | Date of Burial: 5/2 1929

20. Undertaker: Lewis Kiser | Address: Ashton Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 3 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65738

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 13

PLACE OF DEATH
County of Blaine
City of Bellevue
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME H. R. Butler

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day and year) May 10 1852

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72		21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Toledo, Ohio

PARENTS

10. NAME OF FATHER Cor Lewis Butler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Alliance Ohio
12. MAIDEN NAME OF MOTHER Lavinda Eldridge
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rockland Ohio

14. Informant ..... (Address) Chicago, Ill.

15. Filed 5-1, 1929 T. H. Wright — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-20, 1929, to 4-1, 1929
that I last saw him alive on 3-31, 1929
and that death occurred, on the date stated above, at 12 M. m.
The CAUSE OF DEATH* was as follows:
Influenza -

Chronic (duration) yrs. mos. 11 ds.
CONTRIBUTORY (Secondary) Bronchial Asthma
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Robert H. Wright - M. D.
4/2, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bellevue Idaho	April 7 1929

20. Undertaker	Address
Harris & Son	Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 3 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65739

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 14

PLACE OF DEATH
County of Blaine
City of Hailey
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Lunn

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie Robertson Lunn

6. DATE OF BIRTH (month, day and year) Oct 3 - 1878

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	5	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheepman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Rockburgh Scotland

PARENTS
10. NAME OF FATHER Geo Lunn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Jannett Kerr
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs James Lunn
(Address) Hailey Ida

15. Filed 5 - 1, 1929 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

Fox

16. DATE OF DEATH April 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/15, 1929, to April 1st, 1929
that I last saw him alive on April 1st, 1929
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) E. W. Fox, M. D.
April 1, 1929 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey	April 3 1929
20. Undertaker	**Address**
Harris & Lamon	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 3 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65740

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 15
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Francis Ensign
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X
6. DATE OF BIRTH (month, day and year) Feb 17 - 1877
7. AGE Years 52 Months 1 Days 23 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Judge
(b) General nature of industry, business, or establishment in which employed (or employer) Lawyer.
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Silver City Ida

PARENTS
10. NAME OF FATHER F. E. Ensign
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Margaret Reid
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dublin, Ireland

14. Informant [illegible]
(Address) Hailey Idaho
15. Filed 5-1, 1929 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 10 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 4/4 - 1929, to 4/10, 1929
that I last saw him alive on 4/10, 1929
and that death occurred, on the date stated above, at 10:10 a.m.
The CAUSE OF DEATH* was as follows:
Cancer cinoma of Stomach
Liver - Pancreas
..... (duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of 3/20-29
Was there an autopsy? no
What test confirmed diagnosis? at operation
(Signed) E. W. Fox, M. D.
4/17, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hailey Idaho — Date of Burial April 12 1929
20. Undertaker Harris & Amor — Address Hailey

RECEIVED MAY 3 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65741

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 16

PLACE OF DEATH
County of Blaine
City of Hailey

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Barbara Weber

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6. DATE OF BIRTH (month, day and year): Feb 28-1844

7. AGE — Years: 85 — Months: 1 — Days: 19 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: X
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Dover Ohio

PARENTS

10. NAME OF FATHER: John Weber
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Elizabeth Wagner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: A Tandecki Jr
(Address): Hailey Idaho

15. Filed 5-1, 1929 W. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/17, 1929 to 4/17, 1929
that I last saw h er alive on 4/17, 1929
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Senility
Progressive Muscular
Atrophy (duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) E. W. Hawley, M. D.
4/19, 1929 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey Idaho	4-19 1929
20. Undertaker: Hanna & Ramos	Address E 244 Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 3 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65742

PLACE OF DEATH
County of Carey
City of Blaine

Registration District No. 57
Primary Registration District No. 2025
Local Registrar's No. 17

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Almond Thorpe

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 12 1856

7. AGE: 73 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer: Self

9. BIRTHPLACE (city or town) (State or country): Sheffield Eng

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Jack Butcher
(Address): Carey, Ida

15. Filed 5-1, 1929 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/2, 1929, to 4/22, 1929
that I last saw him alive on 4/22, 1929
and that death occurred, on the date stated above, at 3:50 a.m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) E. W. Fox, M. D.
4/23, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: ~~Carey~~ Hailey, Ida
Date of Burial: 4/24 1929

20. Undertaker: Harris & Amos
Address: Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 3 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65743

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No.)
Local Registrar's No. 18

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Alfred Boyd

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 29- 29

7. AGE — Years | Months | Days | If LESS than 1 day, 8 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hailey Ida.

PARENTS

10. NAME OF FATHER Peter Boyd
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Ruth Higgins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Jumpa Ida

14. Informant Peter Boyd
(Address) Smiley - Ida

15. Filed 5-1, 1929 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-29, 1929, to 4-30, 1929
that I last saw h~~im~~ alive on 4-29, 1929
and that death occurred, on the date stated above, at 5.30 p.m.
The CAUSE OF DEATH* was as follows:
Transition un uteri

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Lack of amnion
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Robert H. Wright, M. D.
5-1, 1929 (Address) Hailey

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey Idaho	May 1 1929
20. Undertaker E244 Harris & Ramos	Address Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65744

PLACE OF DEATH
County of Bonner
City of Edgemere
Registration District No. 85
Primary Registration District No. 2185
Local Registrar's No. 7
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Callie Johnson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Johnson

6. DATE OF BIRTH (month, day and year) Nov. 29, 1907

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	4	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Spokane, (State or country) Wash

PARENTS

10. NAME OF FATHER Sidney D. Garvin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Daisy V. Green
13. BIRTHPLACE OF MOTHER (city or town) Loyal, (State or Country) Wis.

14. Informant Carl Johnson
(Address) Edgemere, Idaho

15. Filed apr. 3, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH apr. 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 5:03? m.

The CAUSE OF DEATH* was as follows:
Conflagration; Accidental burning of dwelling. Gasoline Explosion.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) L. L. Moon Coroner
apr 3, 1929 (Address) [redacted], Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane, Wash.	apr. 4 1929
20. Undertaker Moon Mortuary	Address Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65745

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bonner
City of Priest River

Registration District No. 85
Primary Registration District No. 2185
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Catherine Gordon

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Gordon

6 DATE OF BIRTH (month, day and year): June, 30, 1842

7 AGE: Years 86 | Months 9 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Augusta Maine

PARENTS
10 NAME OF FATHER: Mr. Nichols
11 BIRTHPLACE OF FATHER (city or town) (State or country): Maine
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Alice E. Martin
(Address) Spokane, Wash

15 Filed Apr. 4, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 2, (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April first, 1929, to April 2, 1929, that I last saw her alive on April 2, 1929, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
..... (duration) several years yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Physical Signs
(Signed) R. A. Lower M. D.
April 4, 1929 (Address) Priest River Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: I. O. O. F. Cemetery
Date of Burial: Apr. 4, 1929

20. Undertaker: Moon Mortuary
Address: Priest River

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65746

PLACE OF DEATH

County of Bonner
City of Priest River

Registration District No. 85
Primary Registration District No. 2185
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 9

2. FULL NAME Arthur Anthony Naccarato

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb. 26, 1928

7 AGE: Years 1 | Months 1 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Priest River Idaho

PARENTS
10 NAME OF FATHER: Arthur Naccarato
11 BIRTHPLACE OF FATHER (city or town) (State or country): Priest River Idaho
12 MAIDEN NAME OF MOTHER: Christina Maio
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Priest River Idaho

14 Informant Arthur Naccarato
(Address) Priest River, Ida.

15 Filed Apr. 8, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 8 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1929, to April 8, 1929, that I last saw him alive on April 8, 1929 and that death occurred, on the date stated above, at 3 20 XX m.

The CAUSE OF DEATH* was as follows:
Pneumonia
..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Scarlet Fever
..... (duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical Signs
(Signed) R. A. Lower, M. D.
April 6, 1929 (Address) Priest River Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Woodmen Cemetery
Date of Burial: Apr. 9, 1929

20. Undertaker: Moon Mortuary
Address: Priest River

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65747

PLACE OF DEATH

County of Bonner

City of Priest River

Registration District No. 85

Primary Registration District No. 2185

Local Registrar's No. 10

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Naccarato

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 37 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Teresa Naccarato

6. DATE OF BIRTH (month, day and year) Feb. 10, 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	1	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Grimaldi (State or country) Italy

PARENTS

10. NAME OF FATHER George Naccarato

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy

12. MAIDEN NAME OF MOTHER Anna Maio

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant August Naccarato

(Address) Priest River, Idaho

15. Filed Apr. 11, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 9, 1929 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1928, to April 7, 1929 that I last saw him alive on April 7, 1929 and that death occurred, on the date stated above, at 7:00 A.m.

The CAUSE OF DEATH* was as follows:

Cardio Renal Vascular Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) R A Bowers, M. D.

April 10, 1929 (Address) Priest River Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Woodmen Cemetery	Apr. 11, 1929
20. Undertaker	Address
Moon Mortuary	Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65748

PLACE OF DEATH

County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
Local Registrar's No. 11
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Brooks Jr.

(a) Residence. No..... St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 2 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 19 1929

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Priest River, Idaho

PARENTS

10. NAME OF FATHER Fred M. Brooks
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cresco, Iowa
12. MAIDEN NAME OF MOTHER Edna Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Claris Home Canada

14. Informant Fred M. Brooks
(Address) Priest River, Idaho

15. Filed Apr. 14, 1929 R. E. Nurse Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12, 1929, to April 12 1929
that I last saw h[illegible] alive on April 12 1929
and that death occurred, on the date stated above, at 4:00 P. m.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia

(duration) yrs. mos. 10? ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical signs
(Signed) E K Brooks M. D.
April 13, 1929. (Address) Priest River Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I. O. O. F. Cemetery	Apr. 14 1929
20. Undertaker	Address
Moon Mortuary	Priest Rive

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65749

PLACE OF DEATH

County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
Local Registrar's No. 12
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ada Edmonson Stone

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer O. Stone

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	48			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Perry
(State or country) Iowa

PARENTS

10. NAME OF FATHER Benjiman F. Newport
11. BIRTHPLACE OF FATHER (city or town) Springfield
(State or Country) Ill.
12. MAIDEN NAME OF MOTHER Currins
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Virginia

14. Informant Elmer O. Stone
(Address) Coolin, Idaho

15. Filed May 2, 1929 R. E. Wessa, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 29, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:
Accidental Traumatism:
Crushed under Automobile.
500 ft. North Priest River Idaho.
Sandpoint, Priest River Road.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no.
What test confirmed diagnosis? none
(Signed) L. H. Moon Coroner.
April 29, 1929 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Woodmen Cemetery	May 2, 1929
20. Undertaker	Address
Moon Mortuary	Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65750

PLACE OF DEATH
County of Bonner
City of Nordman

Registration District No. 85
Primary Registration District No. 2185
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

2. FULL NAME Nattie Kinyon

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Evin R. Kinyon

6. DATE OF BIRTH (month, day and year) September 3, 1849

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	7	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Henry Babcock
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Nancy Brandon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Roy Kinyon
(Address) Nordman, Idaho

15. Filed May 2, 1929 R. E. Wessa
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 30, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 10:50 A. m.

The CAUSE OF DEATH* was as follows:
Unknown Probably Chronic Heart Disease

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) L. A. Moon — Coroner.
May 1, 19 29 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F. Cemetery	May 2, 1929
20. Undertaker	Address
Moon Mortuary	Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65751

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Day Stafford

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day,
	88			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Uknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Parnell Hospital
(Address) Sandpoint, Idaho

15. Filed April 3, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 24th. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1920, to March 24, 1929
that I last saw him alive on March 23, 1929
and that death occurred, on the date stated above, at 9:30 p m.
The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease
Arteriosclerosis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Floyd C. Wendle, M. D.
Apr. 3, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Apr. 3, 1929
20. Undertaker R.E. Wessa	Address Priest River, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 8 1929

PLACE OF DEATH

County of Bonner

City of Sandpoint

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78

Primary Registration District No. 2155

(No. 310 Church Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 65752

Local Registrar's No.

2. FULL NAME Harriet S. Roberts,

(a) Residence. No. 310 Church Street St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of H.S.Roberts

6. DATE OF BIRTH (month, day and year) October 30th. 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	77	5	3	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Ashville
(State or country) North Carolina

PARENTS

10. NAME OF FATHER Henry Sheppard

11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14. Informant William Kennedy
(Address) Sandpoint, Idaho.

15. Filed April 4, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 3, (Day) 29 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Mar 20, 1929, to April 2, 1929
that I last saw her alive on April 2, 1929
and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Old Age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C E Allen M. D.

April 4, 1929 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Juliaetta, Idaho.	Apr. 5, 1929
20. Undertaker	Address
MOON MORTUARY	Sandpoint, Idaho.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65753

PLACE OF DEATH

County of Bonner
City of Samuels

Registration District No. 78
Primary Registration District No. 2155
(No. Samuels Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Joseph William Schmalhorst

(a) Residence. No. Samuels Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Schmalhorst

6. DATE OF BIRTH (month, day and year) July 14 1856

7. AGE Years 72 Months 8 Days 26 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Henry P Schmalhorst
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Sarah C Leonard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Mrs. Florence Schmalhorst
(Address) Samuels Idaho

15. Filed April 12, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ for Many years, to , 19
that I last saw he alive on , 19
and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:
1. Senility
2. Cardio-vasculo-renal disease-
(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. P. Starkhouse, M. D.
Apr. 10, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lakeview Cemetery
Date of Burial Apr 12 1929

20. Undertaker Turnbull Co.
Address Sandpoint

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65754

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martini Kellen Nelson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 6 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	9	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dover Idaho.

PARENTS

10. NAME OF FATHER Martini Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minnesota
12. MAIDEN NAME OF MOTHER Corinne Larson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minnesota

14. Informant Martini Nelson
(Address) Dover - Idaho.

15. Filed April 14, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 11, 1929
that I last saw him alive on April 11, 1929
and that death occurred, on the date stated above, at 10:30 A.m.
The CAUSE OF DEATH* was as follows:
Pertussis - Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) Floyd G. Wendle, M. D.
April 14, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Crest Cemetery	April 14 1929
20. Undertaker L. G. Moon	Address Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECE[illegible] MAY [illegible] 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65755

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 18
Primary Registration District No. 2155
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Jerome Franklin Cracraft

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Cracraft

6. DATE OF BIRTH (month, day and year): Aug 25 1878

7. AGE: Years 50, Months 7, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10. NAME OF FATHER: William Cracraft
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Mina East
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Emma Cracraft Horn
(Address) Clarksfork Ida.

15. Filed April 15, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 13 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to April 15 1929
that I last saw him alive on April 12, 1929
and that death occurred, on the date stated above, at 6:30 A m.
The CAUSE OF DEATH* was as follows: Influenza - Pneumonia

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Floyd G. Wendle, M. D.
April 15, 1929 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clarksfork, Ida. Date of Burial: April 16 1929

20. Undertaker: L. G. Moon — Address: Sandpoint Ida

RECEIVED MAY [illegible] 1929

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65756

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. .....

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ROBERT BLACK

(a) Residence. No. 820 Lake Street St.
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Samantha Black

6. DATE OF BIRTH (month, day and year) May 9, 1882

7. AGE	Years	Months	Days	If LESS than 1 day,
	46	11	6	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Groceryman

(b) General nature of industry, business, or establishment in which employed (or employer) Deliveryman

(c) Name of employer Pine Street Grocery

9. BIRTHPLACE (city or town) Garrison
(State or country) Missouri

PARENTS

10. NAME OF FATHER S. J. Black

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) N. Carolina

12. MAIDEN NAME OF MOTHER Melvina Jones

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Arkansas

14. Informant Mrs. Samantha Black
(Address) Sandpoint, Idaho.

15. Filed April 18, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 15th. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 15, 1928 to April 15, 1929.
that I last saw h~~im~~ alive on April 15, 1929
and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Influenza following
Operation for suspected
malign tumor.

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY
(Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of March 14, 1929

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. D. Graves M. D.

Apr. 18, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
LAKEVIEW CEMETERY	Apr. 18, 1929
20. Undertaker	Address
MOON MORTUARY	Sandpoint, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65757

PLACE OF DEATH

County of Bonner — Registration District No. 78

City of Sandpoint, Ida — Primary Registration District No. 2155

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mc Hester Harbaugh.

(a) Residence. No. 704 N. Fourth St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 9. 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	2	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky.

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant Mrs Augie Miller

(Address) 704 N Fourth.

15. Filed April 20 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 17 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1924 to April 17, 1929

that I last saw h— alive on April 17, 1929

and that death occurred, on the date stated above, at 4 9 — m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac hypertrophy Arteriosclerosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Sandpoint Ida

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine, blood pressure, symptoms

(Signed) L. G. Moore, M. D.

April 20, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	April 21 1929
20. Undertaker L. G. Moore	Address Sandpoint Ida

RECEIVED MAY 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65758

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. Page Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Frank H Lear

(a) Residence. No. Canyonwood St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 30 1885

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	43	11	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisc.

PARENTS

10. NAME OF FATHER John J Lear

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisc.

12. MAIDEN NAME OF MOTHER Mary Byer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisc.

14. Informant Joseph O Lear
(Address) Canyonwood Ida.

15. Filed April 24, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 23, 1929 to April 23, 1929
that I last saw him alive on April 23, 1929
and that death occurred, on the date stated above, at 3 PM

The CAUSE OF DEATH* was as follows:
Acute intestinal obstruction

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Near Canywood Ida.
Did an operation precede death? No Date of Refused operation
Was there an autopsy?
What test confirmed diagnosis?

(Signed) O Page, M. D.
April 24, 1929 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview	4/24 1929
20. ~~Undertaker~~ Funeral Dir.	Address Sandpoint.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65759

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 3155
Local Registrar's No.
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Meader

(a) Residence. No. County Poor Farm St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs. Eidelbus
(Address) County Poor Farm, Sandpoint Idaho.

15. Filed April 24 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1928, to April 23, 1929
that I last saw him alive on April 20, 1929
and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis
Chronic valvular heart disease (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.
April 24, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Apr. 25 1929

20. Undertaker	Address
R. E. Wessa,	Priest River

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65760

PLACE OF DEATH
County of Bonner
City of Colburn

Registration District No. 18
Primary Registration District No. 2155
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Herbert H. Fenton
(a) Residence. No. Colburn Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nattie Fenton

6. DATE OF BIRTH (month, day and year) April 25, 1857

7. AGE 72 Years ~~about 72~~ | 9 Months — | Days 2 days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Henry J. Fenton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) NY
12. MAIDEN NAME OF MOTHER Helen Rowers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Mrs. Nellie O Hurd
(Address) Colburn Idaho

15. Filed April 25, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at about 1 mp
The CAUSE OF DEATH* was as follows:
Accidental Traumatism: Crushed by falling tree. probable loss of blood.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L. H. Moon Coroner D.
Apr. 24, 1929 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lakeview Cemetery | Date of Burial 4/28 1929

20. Undertaker Turnbull Co | Address Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65761

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maude Critchell

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Critchell

6. DATE OF BIRTH (month, day and year) December 12, 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	4	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Stephen Harrington

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Sarah Bower

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant George Critchell
(Address) Sandpoint, Idaho.

15. Filed May 1, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25, 1929, to April 28, 1929
that I last saw her alive on April 28, 1929
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Cholecystitis
(duration) yrs. 5 mos. ds.
CONTRIBUTORY (Secondary) Pancreatitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes.
Did an operation precede death? Yes. Date of March 29-29
Was there an autopsy? No.
What test confirmed diagnosis? Operation Cholecystotomy
(Signed) O F Cayhy M D
April 30, 1929 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	May 1, 1929

20. Undertaker	Address
Moon Mortuary	Sandpoint Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65762

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2150

Local Registrar's No. 70

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Betty Lou Bertha Schuldt.

(a) Residence. No. 440-3 St. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 9 - 1929.

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
0	1	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Ida

PARENTS

10. NAME OF FATHER Harry Geo Schuldt.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Flora Marker.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho Falls.

14. Informant Flora Marker Schuldt.
(Address) 440-3 St. Idaho Falls.

15. Filed Apr 30, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 29 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 22, 1929, to March 29, 1929 that I last saw her alive on March 28, 1929 and that death occurred, on the date stated above, at 1230 P.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

..... (duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) [signature] M. D.

3-29-1929 (Address) Idaho Falls Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: 3/30 1929.

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65763

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 1 N 7 0
(No.)
Local Registrar's No. 69

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Roselyn Geneva Hansen

(a) Residence. No. Garfield, Idaho St. Garfield, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of E. J. Hansen

6. DATE OF BIRTH (month, day and year) March 16, 1887

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	0	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House-wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spanish Fork Utah

PARENTS

10. NAME OF FATHER John H. Houghton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Elizabeth Ferguson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant J. E. Hansen
(Address) Garfield, Idaho

15. Filed Mar 30, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25, 1929, to March 26, 1929
that I last saw her alive on March 26, 1929
and that death occurred, on the date stated above, at 3:45 P m.
The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No. Ucon, Idaho
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Laboratory

(Signed) [illegible] M. D.
Mch 27, 1929 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho	March 29 1929
20. Undertaker Jack A. Wood	Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65765

PLACE OF DEATH

County of Bonneville.
City of Idaho Falls.
Registration District No. 73
Primary Registration District No. 2156
Local Registrar's No. 67
(No. L. D. S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Parley Franklin Smith.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Leona Pope Smith.

6. DATE OF BIRTH (month, day and year) March. 15-1877.

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	0	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dentist.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Utah.

PARENTS

10. NAME OF FATHER A. D. Smith.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.
12. MAIDEN NAME OF MOTHER Amanda Draper.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Leona Pope Smith
(Address) Idaho Falls Ida.

15. Filed Mar 28, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1-, 1929, to March 26, 1929
that I last saw him alive on March 26, 1929
and that death occurred, on the date stated above, at 4.45 A. m.
The CAUSE OF DEATH* was as follows: Intestinal Hemorrhage from undetermined thrombotic process of gastro-intestinal tract. (duration) ..... yrs. ..... mos. 54 ds.
CONTRIBUTORY (Secondary) Undetermined Meningeal infection (duration) ..... yrs. ..... mos. 54 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? yes - 3-26-29
What test confirmed diagnosis? above
(Signed) H. D. Lueckin, M. D.
3-28, 1929 (Address) Idaho Falls Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: 3/28 1929

20. Undertaker: V. F. McHan Address: Idaho Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65766

PLACE OF DEATH

County of Bonneville. Registration District No. 73
City of Idaho Falls. Primary Registration District No. 2170 Local Registrar's No. 66
(No. Spencer Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas Moody.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Selma Moody.

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 57 | Months 5 | Days 29. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: John Johnson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden.
12. MAIDEN NAME OF MOTHER: Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Mrs Selma Moody.
(Address) Idaho Falls Idaho

15. Filed Mar 23, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 22 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov —, 1928, to March 22, 1929
that I last saw h[illegible] alive on March 22, 1929
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Interstit Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? ✓

(Signed) [signature], M. D.
March 23, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls. Date of Burial: 3/26 1929

20. Undertaker: V. F. McHan Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 22 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65767

Registration District No. 73

Primary Registration District No. 2140

Local Registrar's No. 64

(No. L.D.S.Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lester Petersen Jr.

(a) Residence. No. Ucon, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) November 25, 1919

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
10	3	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ucon, Idaho

PARENTS

10. NAME OF FATHER Lester Petersen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER N ellie Simmons

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ucon, Idaho

14. Informant Lester Petersen
(Address) Ucon, Idaho

15. Filed Apr 23, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 13, 1929, to 3/20, 1929

that I last saw him alive on March 20, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Epidemic Sp. Meningitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral obstruction Respiratory collapse

(duration) yrs. mos. 21 ds.

18. Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Spinal sumatures

(Signed) [signature], M. D.

3/21, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: ~~Xxxxx~~ Ucon, Idaho

Date of Burial: March 23 1929

20. Undertaker: J.A.Wood

Address: Idaho Falls

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65768

Registration District No. 13
Primary Registration District No. 2150
Local Registrar's No. 64

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. L.D.S.Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Florence Esther Chugg

(a) Residence. No. Rupert, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Peter J.Chugg

6. DATE OF BIRTH (month, day and year) July 27.1906

7. AGE	Years	Months	Days	If LESS than 1 day,
	22	7	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Bancroft, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Chris Mortensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Esther Hoopes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Peter J.Chugg
(Address) Rupert, Idaho

15. Filed 4/3/29, 19__ Wm Pennaird Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17, 1929, to March 19, 1929
that I last saw her alive on March 19, 1929
and that death occurred, on the date stated above, at 10:20 p m.
The CAUSE OF DEATH* was as follows:

Epidemic Spinal Meningitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Popular, Idaho
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Spinal punctures

(Signed) W D Scott, M. D.
3/20, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rupert, Idaho	Mar. 22 1929
20. Undertaker	Address
J.A.Wood	Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65769

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 214-1
(No. L W S.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

2. FULL NAME Clarance L. Robinson
(a) Residence. No. South Shelley St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 5 - 1893

7. AGE: 36 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah.

PARENTS
10. NAME OF FATHER: John a Robinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Mary C Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Mrs. Vilate Robinson
(Address) Shelley Idaho

15. Filed Mar 19, 1929 [signature] Registrar
Mr. [signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Typhoid fever
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Shelley
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Lab
(Signed) [signature], M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shelley | Date of Burial: Mch 19 1929

20. Undertaker: Cliff Hazes | Address: Idaho Falls

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65770

PLACE OF DEATH
County of Bonneville
City of Ririe

Registration District No. 73
Primary Registration District No. 2170
Local Registrar's No. 61
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Esther Mortensen

(a) Residence. No. Ririe, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chris Mortensen

6. DATE OF BIRTH (month, day and year) January 20, 1884

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	1	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER H. B. Hooper
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Provo, Utah
12. MAIDEN NAME OF MOTHER Margaret Spindell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs. H. B. Hooper
(Address) Ririe, Idaho

15. Filed March 17, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 10-45a m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Dan F. Price, M. D.
, 19 (Address) Ririe Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ririe, Idaho	Mar. 15 1929
20. Undertaker C. A. Wood	Address Idaho Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65771

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. R.D.S.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 60

2. FULL NAME ~~Infant~~ Harold Kaneko.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Japanese
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 6 - 1929

7. AGE Years: Months 2 Days 7 If LESS than 1 day, ~~8~~ hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Res.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls

PARENTS

10. NAME OF FATHER: I Kaneko.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Japan
12. MAIDEN NAME OF MOTHER: Tomino Waki
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Japan

14. Informant: I Kaneko.
(Address): Idaho Falls

15. Filed Mar 14, 1929 [signature] Registrar
Dr. [signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 12, 1929, to Mar 13, 1929
that I last saw him alive on Mar 12, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
..... (duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary) —
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical & Tray
(Signed) W R Hatch M. D.
Mar 14, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls
Date of Burial: Mch 14 1929

20. Undertaker: Cliff Hayes
Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65772

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. V-7

2. FULL NAME Baby McCallister
(a) Residence. No. 197-14th St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): March 7, 1929
7. AGE: Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Idaho Falls, Idaho

PARENTS
10. NAME OF FATHER: C. P. McCallister
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Grace Beam
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Mr. C. P. McCallister
(Address) Idaho Falls, Idaho

15. Filed Mar 12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 8 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mch 7, 1929, to Mch 8, 1929
that I last saw him alive on Mch 7, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Premature birth
(duration) yrs. mos. 10 hours ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature], M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho | Date of Burial: Mar 8 1929
20. Undertaker: Jack C. Ward | Address: Idaho Falls

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65773

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. L.D.S.Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. V-f

2. FULL NAME Minnie A.Elliott

(a) Residence. No. Ashton, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ervin Elliott

6. DATE OF BIRTH (month, day and year) Sept.25.1886

7. AGE: Years 43 | Months 5 | Days 14 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: William E. ~~Elliottz~~ Sprowel
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Sarah A.Coddley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Mr.Ervin Elliott
(Address) Ashton, Idaho

15. Filed Mar 12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6, 1929, to Mch 9, 1929
that I last saw her alive on Mch 9, 1929
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:
Mesenteric Thrombosis
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary): appendicitis - Uterine fibroid
Several
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ashton Ida
Did an operation precede death? Yes Date of Mch 6-1929
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature], M. D.
, 19__ (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho
Date of Burial: Mar.12 1929

20. Undertaker: J.A.Wood
Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. ~~S. No. 5-25 M-1-19~~ APR 22 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65774
Local Registrar's No. ✓

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3
Primary Registration District No. 2150
(No. Memorial Drive St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orval Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: Sept. (Month) 15 (Day) 1908 (Year)

7. AGE: 20 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ___ hrs. or ___ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Hyrum Campbell

11. BIRTHPLACE OF FATHER (State or Country): Bingham Co Utah

12. MAIDEN NAME OF MOTHER: Alice Fox.

13. BIRTHPLACE OF MOTHER (State or Country): Cottonwood Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hyrum Campbell
(Address) Lorenzo Idaho

15. Filed March 11 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8 1929, to Mar 11 1929, that I last saw him alive on March 11 1929, and that death occurred on the date stated above, at 4 9 M.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebral Spinal Meningitis
(Duration) ___ yrs. ___ mos. 5 ds.

Contributory (Secondary) Pneumonia Lobar
(Duration) ___ yrs. ___ mos. 2 ds.

(Signed) Jabez N. West M. D.
3/11 1929 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ___ yrs. ___ mos. 3 days. In the State ___ yrs. life mos. ___ ds.
Where was disease contracted if not at place of death? Lorenzo Idaho
Former or usual residence Lorenzo Rt#1 Idaho

19. PLACE OF BURIAL OR REMOVAL: Annis Iola
DATE OF BURIAL: 3/12 1929

20. UNDERTAKER: C B Eckersell
ADDRESS: Rigby

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65775

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No.
Local Registrar's No. 6
(No. L.D.S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dean Fowler.

(a) Residence. No. 269 So. Water St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
8	11	13.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls.

PARENTS

10. NAME OF FATHER P. H. Fowler.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana.
12. MAIDEN NAME OF MOTHER Georgia Labrum.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sandy Utah.

14. Informant Mr P. H. Fowler.
(Address) Idaho Falls Ida.

15. Filed Mar 11, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March. 10 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 1, 1929, to Mch 10, 1929
that I last saw him alive on Mch 9, 1929
and that death occurred, on the date stated above, at 8.30 A. m.
The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Laboratory

(Signed) [signature] M. D.
March 11, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls.	Mar 11 1929.
20. Undertaker T. F. McHan.	Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65776

PLACE OF DEATH

County of Bonneville.
City of Idaho Falls.

Registration District No. 13
Primary Registration District No. 2150

Local Registrar's No. V V

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hoyt S. Winer.

(a) Residence. No. Ucon Idaho. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie Winer.

6. DATE OF BIRTH (month, day and year) Oct. 8 1889

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
39.	4	29.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Jasper Iowa.

PARENTS

10. NAME OF FATHER Sylvester Winer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.
12. MAIDEN NAME OF MOTHER Barbara Moon.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Jessie Winer
(Address) Idaho Falls Ida.

15. Filed Mar 8, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him on ....., 19.....
and that death occurred, on the date stated above, at about 10:30 a.m.

The CAUSE OF DEATH* was as follows:
Accidental traumatism by being caught in electric driven water pump jack
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? ..... Date of .....
Was there an autopsy? —
What test confirmed diagnosis? .....

(Signed) Dr. B. J. Allen coroner
Mar 8, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls. Date of Burial: 3/10 1929.

20. Undertaker: V. F. McHan. Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65777

PLACE OF DEATH

County of Bonneville
City of Iona

Registration District No. 13
Primary Registration District No. 2170
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. V-4

2. FULL NAME Vera Ward

(a) Residence. No. Iona, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 1, 1928

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER George J. Ward
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iona, Idaho
12. MAIDEN NAME OF MOTHER Anna L. Loveland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho Idaho

14. Informant George J. Ward
(Address) Iona, Idaho

15. Filed May, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5, 1929, to March 6, 1929, that I last saw her alive on March 5, 1929, and that death occurred, on the date stated above, at 7-30p m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. Fulton, M. D.
3/7/29 19 (Address) Ida Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Iona, Idaho	March 8 1929
20. Undertaker	Address
J.A.Wood	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 22 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65778
Local Registrar's No. V 3

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2140
(No. L. O. S. Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ronald Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caus
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word)

6. DATE OF BIRTH: Jan. (Month) 7 (Day) 1928 (Year)

7. AGE: Yrs. 14 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho Falls Ida.

10. NAME OF Father: George Anderson

11. BIRTHPLACE OF FATHER (State or Country): Salem, Idaho

12. MAIDEN NAME OF MOTHER: Pearl Kelley

13. BIRTHPLACE OF MOTHER (State or Country): Shelley, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. George Anderson
(Address) Shelley Idaho

15. Filed Mar 7 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1929, to March 6 1929, that I last saw him alive on March 6 1929, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(Duration) yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) I. R. Egbert M. D.

Mar 7 1929 (Address) Shelley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence Shelley, Idaho

19. PLACE OF BURIAL OR REMOVAL: Shelley, Idaho
DATE OF BURIAL: Mar 7 1929

20. UNDERTAKER: Jack A. Wood
ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65779

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2170
Local Registrar's No. 1-2
(No. L.D.S.Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Allie Parker

(a) Residence. No. Ogden, Utah St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) September 14, 1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	5	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ~~Iowa~~ ~~Iowa~~ Iowa

PARENTS

10. NAME OF FATHER Nickolas Shaw
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant John Parker
(Address) La Jolla, California

15. Filed 4/7, 19-9 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/2, 1929, to 3/7, 1929, that I last saw h~~e~~r alive on 3/7, 1929, and that death occurred, on the date stated above, at 1-50a m.

The CAUSE OF DEATH* was as follows: Cerebro Spinal Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) [signature] M.D.
3/7, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho	March 8 1929
20. Undertaker	**Address**
J.A.Wood	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65780

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2100
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 51

2. FULL NAME Chiya Kamada
(a) Residence. No. Iona, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Yellow
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of K. Kamada

6. DATE OF BIRTH (month, day and year) March 20 1898

7. AGE Years 31 Months 11 Days 16 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Japan

PARENTS
10. NAME OF FATHER Kihaciro Otaka
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan
12. MAIDEN NAME OF MOTHER Yabli Kimina
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Japan

14. Informant K. Kamada
(Address) Iona, Idaho

15. Filed Apr 6, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1929 to Mar. 4, 1929
that I last saw her alive on Mar. 4, 1929
and that death occurred, on the date stated above, at 3-30 P m.
The CAUSE OF DEATH* was as follows:
Typhoid fever
(duration) ___ yrs. ___ mos. ___ ds.
CONTRIBUTORY (Secondary) Chronic myocarditis and chronic endocarditis
(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? Indefinite
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John O Mellar M. D.
Mar. 5, 1929 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho
Date of Burial Mar 6 1929

20. Undertaker Jack A. Wood
Address Idaho Falls.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 22 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 73

Primary Registration District No. 2110

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65781

Local Registrar's No. V 5

2. FULL NAME Luis Miramontez, Jr.

(a) Residence. No. G Street St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
~~Female~~ Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 21, 1928

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	10	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child at home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Paul, Wyoming

PARENTS

10. NAME OF FATHER Luis Miramontez, Sr.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico

12. MAIDEN NAME OF MOTHER Manuela Cobarubia

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico

14. Informant Luis Miramontez

(Address) G Street, Idaho Falls, Idaho

15. Filed Mar 5, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 2, 1929 to Mar. 3, 1929 that I last saw him alive on Mar. 2, 1929 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

Indefinite (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ~~~~~

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John D. Millar, M. D.

....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rose Hill, Idaho Falls	Mar. 5 1929
20. Undertaker	**Address**
Jack A. Wood	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 1 0 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65782

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. -

2. FULL NAME Alice May Jordan

(a) Residence. ~~No.~~ R.F.D. #3 Nampa, Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Fred W. Jordan

6. DATE OF BIRTH (month, day and year) Sept. 16 - 1892

7. AGE	Years	Months	Days	If LESS than 1 day,
	36	6	18	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work house wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Butler,
(State or country) Missouri.

PARENTS

10. NAME OF FATHER Lee Powell

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Missouri.

12. MAIDEN NAME OF MOTHER Lucy E. Carnahan.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Illinois.

14. Informant Mrs. R. J. Talley
(Address) Boise, Idaho

15. Filed 4-7, 1929. Retha Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 4th 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 26, 1929, to April 4 1929
that I last saw h~~im~~ alive on April 4, 1929
and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O C Bellman M. D.

4-6-, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn, Nampa	4-7 1929
20. Undertaker	Address
Mrs. Nina M. Talley	Nampa, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65783

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 7

Primary Registration District No. 2414

(No. St Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. [illegible]

2. FULL NAME John Calvin Adair

(a) Residence. No. 424 10 ave S. Nampq Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 21 1862

7. AGE Years 67 Months Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER John M. Adair

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Sarah Cummins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Mrs J.C. Adair
(Address) Nampa Idaho

15. Filed 4/14, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 5, 1929, to Apr 12, 1929
that I last saw him alive on April 12 1929
and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
(1) Paralysis Agitans
(2) Progressive Exhaustion
(3) Bulbar Paralysis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Nampa Ida

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Doubtful

(Signed) James Stewart, M. D.

Apr 15, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Nampa Idaho

Date of Burial 4/14/29 19

20. Undertaker F.K. Robinson

Address Nampa Idaho

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65784

Local Registrar's No. 76

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No.

Primary Registration District No.

(No. 104 - Elder St)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME LaFayette Mc Fadden

(a) Residence. No. 104 - Elder St - St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Aug 24 - 1850

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	7	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sheepman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Hugh Mc Fadden

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs L. Mc Fadden
(Address) 104 - Elder St - Nampa Ida

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 14 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 -, 1929, to April 14, 1929
that I last saw h[illegible] alive on April 14 -, 1929
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows: Acute Cardiac Dilitation.
Myocarditis.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Nephritis. Diabetes Mellitus. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel A Swayne M. D.

Ap. 16, 1929 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Idaho	Apr. 17 1929

20. Undertaker	Address
Fred K. Robinson	Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65786

PLACE OF DEATH
County of Canyon
City of

Registration District No.
Primary Registration District No. 201
(No. 11 miles southwest)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 58

2. FULL NAME Dale Gene Miller
(a) Residence. No. 11 miles southwest Nampa St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 21st 1929

7. AGE Years Months Days If LESS than 1 day, 3½ hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER C. H. Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Elda Larsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ashton Idaho

14. Informant Mr. C. H. Miller
(Address) Huston R.F.D. #2 Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 21st (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to April 21, 1929
that I last saw her alive on April 21, 1929
and that death occurred, on the date stated above, at 11:30 P. m.
The CAUSE OF DEATH* was as follows:
Premature birth
(lived 4 hours)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Toremia of Mother
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. Bellamy M. D.
Apr 26, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn - Nampa
Date of Burial: 4-23 1929

20. Undertaker: Wm D. Talley
Address: Nampa, Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65787

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 2 0 0 6

(No. Samaritan Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 59

2. FULL NAME Dorothy Irene Chadwell

(a) Residence. No. Owyhee Co St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem.	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sep. 5 1923

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
6	7	22	

8. OCCUPATION OF DECEASED none

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wash.

PARENTS

10. NAME OF FATHER C.G.Chadwell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vir.

12. MAIDEN NAME OF MOTHER Delona Conden.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Chas G.Chadwell

(Address) Givens Springs Idaho

15. Filed 5/1/, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27, 1929, to Ap. 27-, 1929
that I last saw h[illegible] alive on April 27, 1929
and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

2nd degree burn of 3/4 body area

(duration) yrs. mos. 16 hrs dys

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel A Swayne M. D.

Ap. 30, 1929 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa, Idaho	19

20. Undertaker	Address
F.K.Robinson	Nampa Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

May 25th, 1929.

Dr. S. A. Swayne,

Nampa, Idaho. Re: 65787

RECEIVED MAY 28 1929

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Dorothy Irene Chadwell who died Apr. 27th, 1929.
You gave as cause of death: "2nd degree burn of 3/4 body area".

Information DESIRED in order to complete certificate:

As the different kind of burns are separately classified will you kindly give more particulars as to the cause of the burn. Also advise if a burning building was involved.

PLEASE ANSWER BELOW:

Child came to close to open fire and clothing became ignited. Building did not burn.

Samuel A. Swayne. M.D.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65788

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1056
(No. 1103-13th Ave. So.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 60

2. FULL NAME Charles C. Griffard

(a) Residence. No. 1103-13th Ave. So. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Marry Griffard

6. DATE OF BIRTH (month, day and year) Oct 26, 1840

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
88	6	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Mrs. Geo Tussing
(Address) American Falls Ida

15. Filed 5/1, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-9, 1929, to 4-27, 1929
that I last saw h~~im~~ alive on 4-26 1929
and that death occurred, on the date stated above, at 9:45 P.M.
The CAUSE OF DEATH* was as follows: Heart failure.

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia.
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed ~~diagnosis~~?

(Signed) J. C. Horton M. D.
4-30, 1929 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Catholic Cemetery - Nampa	4-30 1929
20. Undertaker	Address
Wm D. Talley	Nampa, Ida

TION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65789

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 61
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arthur F. Silver

(a) Residence. No. 519-7th Ave. No. St. (Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Sept 10-1865
7. AGE — Years: 63 — Months: 6 — Days: 10 — If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Retired
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Monroe Wis

PARENTS
10. NAME OF FATHER: Ezra Silver
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Elizabeth Crompton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio.

14. Informant: Mrs A. F. Silver
(Address) 519-7th Ave No Nampa Ida

15. Filed 4/24, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1926, to Apr 20, 1929
that I last saw him alive on Apr 20, 1929
and that death occurred, on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Diabetes and Chronic Interstitial Nephritis
(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Urinalysis
(Signed) H. P. Rosa M. D.
4/25, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Kohlerdown Cem — Date of Burial: 4-24 1929
20. Undertaker: Fred K Peterson — Address: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65790

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 2
Primary Registration District No. [illegible]
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 62

2. FULL NAME Marion W. Bell

(a) Residence. No. Dewey-Rodeo Blvd St.
(Usual place of abode)
Length of residence in city or town where death occurred. 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Echo E. Bell

6. DATE OF BIRTH (month, day and year) Nov 20-

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	5	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Chas Wadley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Ann Miles
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Emma A. Bell
(Address) Dewey-Rodeo Blvd

15. Filed 5/1, 1929 Martha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 4, 1929, to May 1, 1929
that I last saw he alive on May 1, 1929
and that death occurred, on the date stated above, at 7.45 p m.
The CAUSE OF DEATH* was as follows:
Myocarditis following Influenza
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical signs
(Signed) J. H. P. Rock, M. D.
May 1, 1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rosedale Cem	5-3 1929
20. Undertaker	Address
Fred R. Peterson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65791

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 63

2. FULL NAME Lillie Elizabeth Allen
(a) Residence. No. 312 - 9 Ave. North St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 8 - 1852

7. AGE Years 76 Months 4 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS
10. NAME OF FATHER John Ormston
11. BIRTHPLACE OF FATHER (city or town) (State or Country) London, England
12. MAIDEN NAME OF MOTHER Jane Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Manchester, England

14. Informant Merritt Le Gore
(Address) 312 - 9th Ave. North, Nampa, Idaho

15. Filed [illegible], 1929 [illegible] Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 1 (Month) — (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Ap. 26, 1929, to May 1, 1929
that I last saw her alive on Ap. 30, 1929
and that death occurred, on the date stated above, at 7 A m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary) Arterio-sclerosis & nephritis. (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Samuel A Swayne M. D.
May 3, 1929 (Address) Nampa, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rohlehaven Nampa — Date of Burial 5/3 1929
20. Undertaker Fred K. Robinson — Address Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65792

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 64

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna E. Scott

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of J. W. Scott

6. DATE OF BIRTH (month, day and year) May 22nd 1870

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58	11	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: house wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Harrisburg
(State or country) Kentucky

PARENTS

10. NAME OF FATHER H. J. Burns

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Mary J. Carter

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Kentucky

14. Informant Mr. J. W. Scott
(Address) Nampa, Idaho

15. Filed 5/1, 1929 Bertha Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26, 1928, to Apr. 28, 1929 that I last saw her alive on April 28, 1929 and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows: Cholecystolithiasis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Adhesion with obstruction at Pylorus end of stomach

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Thos. E. Mangum M. D.

May 1, 1929 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rohr Lawn

Date of Burial: 5/2 1929

20. Undertaker: Mrs. Nina Malley

Address: Nampa

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65793

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Hilton Loyd.

(a) Residence No. Parma # 2 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Loyd.

6. DATE OF BIRTH (month, day and year) July -

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Jemisse Loyd.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jemisse.
12. MAIDEN NAME OF MOTHER Sophia Neely
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia.

14. Informant Emma Loyd.
(Address) Parma # 2

15. Filed 5/10, 1929 Ruth Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to Mar 5, 1929 that I last saw h~~im~~ alive on May 5, 1929 and that death occurred, on the date stated above, at 1-30a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) D. M. Mitchell, M. D.
5/6, 1929 (Address) Parma Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Mountain City Penn	
20. Undertaker C. V. Peckham	Address Caldwell Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65794

PLACE OF DEATH
County of Gambon
City of RECEIVED

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Edward B. Jones
(a) Residence. No. Malad Idaho St. Malad, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Candace Jones.

6. DATE OF BIRTH (month, day and year) Sept 8-1870

7. AGE Years 58 Months 7 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wales

PARENTS
10. NAME OF FATHER Owen Jones.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales.
12. MAIDEN NAME OF MOTHER Alice Llewellyn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales.

14. Informant David M Williams
(Address) Malad Idaho

15. Filed 4-15, 1929 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13, 1929, to April 15, 1929
that I last saw his alive on April 14, 1929
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Bladder
(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) 0
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? 0 Date of
Was there an autopsy? 0
What test confirmed diagnosis? Cystoscopy of Bladder
(Signed) Elis Kaik Jr, M. D.
4-15-, 1929 (Address) Sedr Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Malad Idaho
Date of Burial 19

20. Undertaker
Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65795

PLACE OF DEATH
County of Bonneville
City of Idaho Falls Registration District No. 82
Primary Registration District No. 2159
Local Registrar's No. 9
(No. Carstens Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. H. W. Buck

(a) Residence. No. Cokeville Wyo St. Cokeville, Wyo
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of H. W. Buck

6. DATE OF BIRTH (month, day and year) Sept 21 - 1895

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	33	7	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Charles Idaho

PARENTS

10. NAME OF FATHER Frans Swensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Bessie Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant H. W. Buck
(Address) Cokeville Wyo

15. Filed 4-29-1929 Dr. Russell Tyler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12, 1929, to April 28, 1929
that I last saw h[illegible] alive on April 28, 1929
and that death occurred, on the date stated above, at 8:10 a. m.
The CAUSE OF DEATH* was as follows:

Left Lobar Pneumonia

(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Double Acefingitis
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? Cokeville Wyo
Did an operation precede death? yes Date of 4/13/29.
Was there an autopsy? no
What test confirmed diagnosis? Operation & Physical
(Signed) Ellis Handley M. D.
4-29, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cokeville Wyo	5-2- 1929

20. Undertaker C. L. Putnam Address Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65796

PLACE OF DEATH

County of Caribou
City of Soda Springs

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 10

2. FULL NAME Kay Charles Bowler

(a) Residence. No. Soda Springs Ida St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day and year): April 7 29

7 AGE: Years | Months | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Soda Springs Ida

PARENTS

10 NAME OF FATHER: Charles C Bowler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Turner Ida

12 MAIDEN NAME OF MOTHER: Melda Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Soda Springs Ida

14 Informant: Charles C. Bowler
(Address): Soda Springs Ida

15 Filed 4-25 1929
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 24 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1929, to April 24, 1929, that I last saw him alive on April 23, 1929, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

~~Icterus Neonatorum~~
Premature birth - about 7 mos. wk Gest.
(Cause unknown) (duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary): Icterus Neonatorum
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Russell Tigert, M. D.
4/25 1929 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Soda Springs Ida
Date of Burial: 4-26 1929

20. Undertaker: E L Whitman
Address: Soda Springs

rmation on this certificate is an exact COPY of the official certificate at place of death.

RECEIVED MAY 0

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65797

PLACE OF DEATH

County of Bonner

City of Sedu Spring

Registration District No. 8 2

Primary Registration District No. 2 1 5 7

Local Registrar's No. 11

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Matilda Peterson

(a) Residence. No. Base Idel St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	10	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Candy Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer T. O Smiths

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER L. O Peterson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Lena Erickson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant .....
(Address) .....

15. Filed 4/26, 1929 D. Runnoes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 23, 1929, to April 25, 1929, that I last saw h[illegible] alive on April 25, 1929, and that death occurred, on the date stated above, at 1:15 p.m.

The CAUSE OF DEATH* was as follows:

Peritonitis, Pelvic, Tramatic

..... (duration) ..... yrs. ..... mos. 4 2 ds.

CONTRIBUTORY (Secondary) Dying by blood

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? V

Did an operation precede death? Yes Date of 4-22-29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Eric Kaufman, M. D.

4-25-29, 19..... (Address) Sedu Spring

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Id	4/27 1929

20. Undertaker M W Hendricks Address Preston

RECEIVED MAY 6

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65798

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. Caribou Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

2. FULL NAME Stratford W. Horsley
(a) Residence. No. Soda Springs Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec. 22-1900
7. AGE Years 28 Months 4 Days 0 If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Wilford Steadman
9. BIRTHPLACE (city or town) (State or country) Soda Springs Ida

PARENTS
10. NAME OF FATHER George S. Horsley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Alice Ellen Campbell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Soda Springs Ida

14. Informant Geo. S. Horsley
(Address) Soda Springs Idaho
15. Filed 4-23, 1929 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 22 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 3, 1929, to April 22, 1929
that I last saw her alive on April 22, 1929
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Ruptured Appendix
(duration) yrs. mos. 18 ds.
CONTRIBUTORY (Secondary) 0
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? 7 Date of 4-22-29
Was there an autopsy? 0
What test confirmed diagnosis? Examination
(Signed) Ernest Kaufman, M. D.
4-23, 1929 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida
Date of Burial 4-25 1929
20. Undertaker G. D. Whitman Address Soda Springs Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65799

PLACE OF DEATH MAY 8 1929

County of Cassia
City of Albion
Registration District No. 119
Primary Registration District No. 2198
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alfa Irene Lewis

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Jan. 1, 1929
7. AGE — Years: — Months: 3 — Days: 8 — If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Albion Ida.

PARENTS
10. NAME OF FATHER: LeRoy Lewis
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Albion Idaho.
12. MAIDEN NAME OF MOTHER: Alice Clark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Albion Ida

14. Informant: Hyrum S Lewis
(Address): Declo Ida.
15. Filed May 4 1929 C. F. Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 8 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to April 8, 1929, that I last saw h[illegible] alive on April 8, 1929, and that death occurred, on the date stated above, at 9:30 P m.
The CAUSE OF DEATH* was as follows: Cerebro Spinal Meningitis
Epidemic
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): None
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) C. F. Davis M. D.
5/14, 1929 (Address) Malta Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Albion Ida.	April 9 1929
20. Undertaker: W. E. Johnson	Address: Burley

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65800

PLACE OF DEATH
County of Cassia
City of Elba
Registration District No. 119
Primary Registration District No. 2197
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Darrel R Udy

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: No
6. DATE OF BIRTH (month, day and year): April 5, 1923
7. AGE: Years: 6 | Months: | Days: 4 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Elba Ida

PARENTS
10. NAME OF FATHER: Lot J Udy
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Elba Ida
12. MAIDEN NAME OF MOTHER: Etta Rich
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Mrs Etta Udy
(Address) Elba Ida
15. Filed Apr 4, 1929 E J Sales Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 2, 1929 to April 9, 1929
that I last saw him alive on April 8, 1929
and that death occurred, on the date stated above, at 6:30 P m.
The CAUSE OF DEATH* was as follows:
Stomach poisoning.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): None
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of —
Was there an autopsy? No What test confirmed diagnosis? Symptoms
(Signed) E J Sales, M. D.
2-14, 1929 (Address) Malta Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Elba Ida	April 11 1929
20. Undertaker: D. C. Johnson	Address: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65802

PLACE OF DEATH
County of Cassia
City of Albion
Registration District No. 114
Primary Registration District No. 2198
(No. .....)
Local Registrar's No. .....

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oliver Pearce Anderson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Lillie Anderson

6. DATE OF BIRTH (month, day and year) Feb. 23, 1863

7. AGE	Years	Months	Days	If LESS than 1 day,
	66	1	23	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS

10. NAME OF FATHER Oliver Irwin Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Mary Holleom
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Wm Anderson
(Address) Albion, Idaho

15. Filed May 4, 1929 C. I. Slater Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9, 1929 to Apr 16, 1929
that I last saw him alive on April 15, 1929
and that death occurred, on the date stated above, at 2.30 P m.
The CAUSE OF DEATH* was as follows:
Bronchial pneumonia

(duration) — yrs. — mos. 10 ds.
CONTRIBUTORY (Secondary) Appendicitis
(duration) — yrs. 1 mos. 4 ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C. I. Slater, M. D.
5/14, 1929 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Albion Ida.	April 18 1929
20. Undertaker	Address
W. E. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65803

PLACE OF DEATH
County of Cassia
City of Albion

Registration District No. 119
Primary Registration District No. 2198

Local Registrar's No.

(No. ..... St. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ulysses Grant Calvert

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Cora Bell Calvert

6. DATE OF BIRTH (month, day and year) May 3, 1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	60	11	13	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Telegrapher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Wm A Calvert
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Eliza Ann
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Cora Bell Calvert
(Address) Albion Idaho

15. Filed May 4, 1929 C. F. Sabin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4, 1927 to April 16, 1929
that I last saw him alive on April 2, 1929
and that death occurred, on the date stated above, at 4:30 P m.
The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart

(duration) - yrs. - mos. 10 ds.
CONTRIBUTORY (Secondary) Nephritis
(duration) 1 yrs. 7 mos. 12 ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Typical
(Signed) C. F. Sabin M. D.
5/4, 1929 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls	April 22 1929
20. Undertaker D. E. Johnson	Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65804

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Williams Edward Kipp

(a) Residence. No. 329 South Normal St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Hattie Kipp

6. DATE OF BIRTH (month, day and year) April 26, 1864

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	11	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Grocery
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS

10. NAME OF FATHER Philip Kipp
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Rebecca Slaughter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Hattie Kipp
(Address) Burley Ida

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27, 1929, to March 29, 1929,
that I last saw him alive on , 19 ,
and that death occurred, on the date stated above, at 12 P. m.
The CAUSE OF DEATH* was as follows: Arteriosclerosis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Paralysis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Joseph Hannah M. D.
, 19 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Mar. 31 1929
20. Undertaker D. E. Johnson	Address Burley

RECEIVED APR 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65805

PLACE OF DEATH
County of Cassia
City of Burley R.F.D.

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Magnus Holm
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 12, 1838

7. AGE: Years 91 Months 2 Days 15 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweeden

PARENTS
10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweeden
12. MAIDEN NAME OF MOTHER: Sophia Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweeden

14. Informant: Mrs Carl Anthon
(Address) Burley Ida

15. Filed Apr 8, 1929 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 11 A. m.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
No doctor in attendance
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) P. C. Johnson Coroner, M. D.
Mar. 28, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Springville Ut. Date of Burial: Mar 31 1929

20. Undertaker: D. C. Johnson Address: Burley

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65806

Registration District No.
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Cassia
City of Burley
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Betty Jean Lewis

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 16 1927

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	11	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Idaho

PARENTS
10. NAME OF FATHER E A Lewis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oregon
12. MAIDEN NAME OF MOTHER Mildred Roberson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant C M Roberson
(Address) Burley Idaho

15. Filed Mar 8, 1929 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 18, 1929, to Mar 18, 1929
that I last saw her alive on Mar 18, 1929
and that death occurred, on the date stated above, at 8:30 P.m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
(duration) yrs. mos. 1 ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? Clinical Evidence
(Signed) Hugh E Dean, M. D.
Mar 20, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Idaho	Mar 19 1929
20. Undertaker	Address
D. E. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65807

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nephi Williamson Jolley

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Delpha Jolley
6. DATE OF BIRTH (month, day and year): Dec. 4 1881
7. AGE — Years: 47 | Months: 3 | Days: 12 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS
10. NAME OF FATHER: Reuben K Jolley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Emma Pace
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Payson Utah

14. Informant: Mrs W. E. Smiley
(Address): Burley Ida
15. Filed Apr 8, 1929 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 16 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 15, 1929, to March 16, 1929
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 12 a. m.
The CAUSE OF DEATH* was as follows:

Appendicitis
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. O. Nielson M. D.
3/20, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Mar 19 1929
20. Undertaker: D. E. Johnson	Address: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65808

Registration District No.
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Cassia
City of Burley
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Paul Wardell Pipton

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Dec. 22, 1928

7. AGE — Years: — Months: 2 Days: 9 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Burley Cassia Co Ida

PARENTS

10. NAME OF FATHER: Joseph Cooper Pipton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Taylorsville Utah
12. MAIDEN NAME OF MOTHER: Julia Deane
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Logan Utah

14. Informant: J. C. Pipton Jr.
(Address): Burley Ida

15. Filed Apr 17, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 1 (Month) (Day) 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 24th 29 to Mar 1st, 1929
that I last saw h[illegible] alive on Mar 1st, 1929
and that death occurred, on the date stated above, at — 2[illegible] m.
The CAUSE OF DEATH* was as follows:
1. Broncho-pneumonia
(duration) — yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A. H. Cooper, M. D.
Mar 20, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	May 3 1929
20. Undertaker	Address
D. E. Johnson	Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65809

PLACE OF DEATH
County of Minedoka
City of Rupert

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Kenneth Ivan Merrill

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 12, 1914

7. AGE Years 14 Months 3 Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Burley Ida
(State or country) R.F.D. 2

PARENTS

10. NAME OF FATHER Ivan A Merrill

11. BIRTHPLACE OF FATHER (city or town) Smithfield
(State or Country) ~~Carr~~ Nt.

12. MAIDEN NAME OF MOTHER Carrie Grey

13. BIRTHPLACE OF MOTHER (city or town) Albion Ida
(State or Country)

14. Informant Ivan Merrill
(Address) Burley Ida

15. Filed Apr 8, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12th, 1929, to Feb 26, 1929
that I last saw him alive on Feb. 26, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) yrs. mos. 16 ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? yes Date of Feb. 12-29
Was there an autopsy? no
What test confirmed diagnosis? -
(Signed) G. H. Cooper M. D.
Mar. 20, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Albion Ida. Date of Burial Mar. 1 1929

20. Undertaker D. E. Johnson Address Burley.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65810

PLACE OF DEATH

County of Cassia
City of Burley P.O.

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Philip Peterson

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years: about 25 yrs | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Minn

PARENTS

10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: D. E. Johnson
(Address) Burley Ida.

15. Filed Apr 28, 1929 F H Courtis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 20 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1929, to , 19
that I last saw h alive on , 19
And that death occurred, on the date stated above, at 8: A. m.

The CAUSE OF DEATH* was as follows:
Hemorage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Epilepsy
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) D. E. Johnson Coroner
April 28, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Perham Minn — Date of Burial 19
20. Undertaker: D. E. Johnson — Address Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 13 1929

PLACE OF DEATH

County of Cassia

City of Burley R F D

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65811

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nancy Alice Goodfellow

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: S B Goodfellow

6. DATE OF BIRTH (month, day and year): Oct 9 1884

7. AGE — Years: 44 | Months: 9 | Days: 6 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) Bountiful (State or country) Davis Co Utah

PARENTS

10. NAME OF FATHER: Karen Solman

11. BIRTHPLACE OF FATHER (city or town) (State or Country):

12. MAIDEN NAME OF MOTHER: Emma Briggs

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wisconsin

14. Informant: S. B. Goodfellow

(Address) Burley Idaho

15. Filed Apr 17, 1929 F. H. Butler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 15 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to April 15, 1929

that I last saw her alive on April 15, 1929

and that death occurred, on the date stated above, at 7:25 P m.

The CAUSE OF DEATH* was as follows:

~~Influenza~~ Diabetes

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hugh E Dean, M. D.

April 18, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bountiful Utah	April 19 1929
20. Undertaker	Address
D. E. Johnson	Burley

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65812

PLACE OF DEATH

County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No. 1627)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME George Vaness Brim
(a) Residence. No. 162 North Conant St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Irene Brim
6. DATE OF BIRTH (month, day and year) Jan. 30, 1843
7. AGE Years 86 Months 2 Days 11 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS
10. NAME OF FATHER Alexander Brim
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Anna Bishop
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Eugene Brim
(Address) Burley Ida.
15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 11 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 1st, 1929, to April 11, 1929
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 5:07 P m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? H. O. Nielson M. D.
4/13 (Signed) , 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida. Date of Burial April 14 1929
20. Undertaker D. E. Johnson Address Burley

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65813

Registration District No.
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Cassia
City of Burley
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Parke

(a) Residence. No. 726 No Conant St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Harris Parke

6. DATE OF BIRTH (month, day and year) May 31, 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	10	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Willard, Utah

PARENTS
10. NAME OF FATHER Charles Parke
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Douglas Parke
(Address) Burley Ida.

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20th, 1929, to April 6-, 1929
that I last saw h-im alive on April 5-, 1929
and that death occurred, on the date stated above, at 11.30 P m.
The CAUSE OF DEATH* was as follows:
Cancer of stomach

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) -
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? - X. Ray

(Signed) A. W. Cooper, M. D.
April 12 1929 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Albion Ida	April 9 1929
20. Undertaker	Address
D. C. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65814

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Reva Joan Morrison

(a) Residence. No. 146 South Overland St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	S.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 11 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida

PARENTS
10. NAME OF FATHER John Morrison
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Weber Co Utah
12. MAIDEN NAME OF MOTHER Priscilla Clayton
13. BIRTHPLACE OF MOTHER (City or town) (State or Country) Utah

14. Informant John Morrison
(Address) Burley Ida

15. Filed May 8, 1929 F. H. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3, 1929, to April 4, 1929
that I last saw her alive on April 4, 1929
and that death occurred, on the date stated above, at 2:a: m.

The CAUSE OF DEATH* was as follows:
Bronchio - Pneumonia
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Colitis
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E Adams, M. D.
April 4, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	April 7 1929
20. Undertaker	Address
D. C. Johnson	Burley

RECEIVED MAY 1 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65815

PLACE OF DEATH

County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gladys Brown Palmer

(a) Residence (Usual place of abode) No. 532 East Main St.

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of W. W. Palmer

6. DATE OF BIRTH (month, day and year) Nov. 1898

7. AGE	Years	Months	Days	If LESS than 1 day,
	30	4		hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Logan Ut

PARENTS

10. NAME OF FATHER William S Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cache Co Utah
12. MAIDEN NAME OF MOTHER Carrie Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Logan Utah

14. Informant W. W. Palmer
(Address) Burley Ida

15. Filed Apr 4, 1929 F. H. Carter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 2 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1928, to April 2nd, 1929, that I last saw h alive on April 2, 1929, and that death occurred, on the date stated above, at 1.00 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Nephritis - Cardiac lesion

(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) H. D. Nielson M. D.
4/4, 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Malad Ida	April 6 1929
20. Undertaker D. C. Johnson	Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65816

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 87

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Orran Daniel Sanchez

(a) Residence. No. Grangemont St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican & Spanish
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) May 14 1926

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
2	10	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓ None
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Consul Idaho

PARENTS

10. NAME OF FATHER John Sanchez
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colorado
12. MAIDEN NAME OF MOTHER Leda Spears
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oklahoma

14. Informant Father John Sanchez
(Address) Grangemont

15. Filed May 1, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 2nd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19..., to ✓, 19...
that I last saw h ✓ alive on ✓, 19...
and that death occurred, on the date stated above, at 12 30 P m.
The CAUSE OF DEATH* was as follows:
not known, tests sent in - Was dead when I arrived
(duration) ..... yrs. 18 hours mos. ..... ds.

CONTRIBUTORY (Secondary) ✓
✓ (duration) ..... yrs. ✓ mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No. Spinal fluid & swabs
What test confirmed diagnosis? ✓
(Signed) J. H. Robertson, M. D.
4/3, 1929 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Council Ida
Date of Burial: 19

20. Undertaker: W. D. Pinson
Address: Orofino Ida

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65817

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 36

2. FULL NAME Robinson H McKinney
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Singer
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 28 - 1874
7. AGE: Years 54, Months 7, Days 7. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Wash

PARENTS
10. NAME OF FATHER: Chas McKinney
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Sarah Russell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Clara Grinny Conger
(Address) Los Angeles Cal

15. Filed May 1, 1929. H A Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 5, 1929
that I last saw him alive on April 5, 1929
and that death occurred, on the date stated above, at 10:30 P m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary): Acute Nephritis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical and laboratory findings
(Signed) O M Husted M. D.
April 5, 1929 (Address) Orofino Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Ida
Date of Burial: 19

20. Undertaker: H A Shaw
Address: Orofino

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65818

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 50
Primary Registration District No. 2177
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 39

2. FULL NAME Eldora Lohness

(a) Residence. No. ____ St. Ferdinand, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unascertained

6 DATE OF BIRTH (month, day and year) May 2, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	62	10	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10 NAME OF FATHER Levi H. Lohness

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unascertained

12 MAIDEN NAME OF MOTHER Emily Elizabeth Lohness

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unascertained

14 Informant Records: Northern Idaho Sanitarium.
(Address) Orofino - Idaho.

15 Filed May 1-, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 31 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to March 31, 1929, that I last saw her alive on March 31, 1929, and that death occurred, on the date stated above, at 11:10 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular heart disease -
(mitral regurgitation) -
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Involution melancholia
(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted ✓ if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) [signature] M. D.
March 31, 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Northern Idaho Sanitarium Cem.	Apr. 4 1929
20. Undertaker	Address
F. A. Billberg, Hosp. Attat.	Orofino, Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MAKE NO ERASURES OR ALTERATIONS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65819

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2157

Local Registrar's No. 40

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Helen Kolasa

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Femal
4. COLOR OR RACE: Whirt
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Frank Kolasa

6. DATE OF BIRTH (month, day and year): Dec 28 1873

7. AGE: Years 55 | Months 9 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Neb

PARENTS

10. NAME OF FATHER: Frank Zelinka
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Neb
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ✓

14. Informant: Rena Kolasa
(Address): Lewiston

15. Filed May 1, 1929 W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8 (Day) 1929 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 8 00 a m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemmorage
Found dead in the bed

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) W. A. Shaw Coroner, M. D.
4/8, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	April 10
20. Undertaker	Address
W. A. Shaw	Orofino

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65820

PLACE OF DEATH

County of Clearwater
City of Orofino

Registration District No. 70
Primary Registration District No. 2187

Local Registrar's No. 41

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nick Marshall

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 50			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Logger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) L

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) L

12. MAIDEN NAME OF MOTHER L

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) L

14. Informant W A Shaw Coroner

(Address) Orofino Ida

15. Filed May 11, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Suicidal by drinking
Two ounces of Carbolic Acid

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. A. Shaw Coroner, M. D.

4/11, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	4/15 1929
20. Undertaker	**Address**
W. L. Pinson	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65821

PLACE OF DEATH

County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2178

Local Registrar's No. 42

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wilmer Wilkinson

(a) Residence. No. _____ St. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 7 1911

7. AGE	Years	Months	Days	If LESS than 1 day,
	18	3	4	_____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Org

PARENTS

10. NAME OF FATHER Roy Wilkinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant R J. Wilkinson
(Address) Orofino Ida

15. Filed April 12, 1929 H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4, 1929, to April 11, 1929
that I last saw h~~im~~ alive on April 10, 1929
and that death occurred, on the date stated above, at 4.40 A m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) _____ yrs. _____ mos. 7 ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? no Date of _____
Was there an autopsy? no
What test confirmed diagnosis? Clinical and Laboratory findings

(Signed) O M Husted, M. D.
4/12, 1929 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	April 14 1929
20. Undertaker	**Address**
H. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65822

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 93
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 43

2. FULL NAME Cassius C. Grigson

(a) Residence. No. ..... St. Orofino - Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 0 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) September 8, 1867

7 AGE: Years 61 | Months 4 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Traveling Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bracken County Kentucky

PARENTS
10 NAME OF FATHER: Oliver Perry Grigson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Kentucky
12 MAIDEN NAME OF MOTHER: Sarah Young
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kentucky

14 Informant: Records: Northern Idaho Sanitarium
(Address) Orofino — Idaho.

15 Filed April 12, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 12 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1929, to April 12, 1929, that I last saw him alive on April 11, 1929, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease (mitral regurgitation).
(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Psychosis with cerebral arterio-sclerosis (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs.
(Signed) John Irvine McKelway, M. D.
April 12, 1929 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Orofino Ida
Date of Burial: 4/14 1929

20. Undertaker: [signature]
Address: Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 6 1929

PLACE OF DEATH

County of Clearwater

City of Orofino

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 2157

DO NOT WRITE IN THIS SPACE
State File No. 65823

Local Registrar's No. 44

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vilo Savage

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 21 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Orofino Ida
(State or country)

PARENTS

10. NAME OF FATHER Edward Savage

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) —

12. MAIDEN NAME OF MOTHER Lena Askey

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) —

14. Informant Mrs Nelson Hospital
(Address) Orofin

15. Filed April 12, 1929. W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3, 1929, to Apr. 11, 1929, that I last saw h[illegible] alive on Apr. 3, 1929, and that death occurred, on the date stated above, at 7.30 PM

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) R. J. Hopkins M. D.

Apr. 11, 1929 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	April 13 1929

20. Undertaker	Address
W. A. Shaw	Orofino

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65824

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 46

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Not Named

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): April 16 1929

7. AGE: Years | Months | Days | If LESS than 1 day, 4 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Orofino Ida

PARENTS
10. NAME OF FATHER: Chas Cooper
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Boise Ida
12. MAIDEN NAME OF MOTHER: Mary L. Deen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ida

14. Informant: Chas Cooper
(Address): Orofino

15. Filed April 16, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h..... alive on ....., 19...
and that death occurred, on the date stated above, at 12 30 P m.
The CAUSE OF DEATH* was as follows:
Immature
Mother Flu Pneumonia
(7 mo) Nervous Bayonne
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? none
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) [illegible], M. D.
Apr 25th, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino
Date of Burial: April 17 1929

20. Undertaker: W. A. Shaw
Address: Orofino

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65825

Local Registrar's No. 48

PLACE OF DEATH

County of Clearwater
City of Orofino
Registration District No. 96
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mandy Kalleo

(a) Residence. No. ..... St. Coeur d'Alene, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sam Kalleo

6 DATE OF BIRTH (month, day and year) Unascertained

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Finland

PARENTS

10 NAME OF FATHER Unascertained

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unascertained

12 MAIDEN NAME OF MOTHER Unascertained

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unascertained

14 Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15 Filed 4/19, 1929 W. A. O'Hara Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 16 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to April 16, 1929, that I last saw her alive on April 16, 1929, and that death occurred, on the date stated above, at 8.05 P. m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis.

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Dementia praecox - Paranoid type (duration) 12 yrs. + mos. + ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs.
(Signed) John Irvine McElway, M. D.
April 16, 1929 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Northern Idaho San. Cemetery — Date of Burial: April 19 1929

20 Undertaker: F. A. Billberg, Hosp. Attdt. — Address: Orofino, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Rob RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65826

PLACE OF DEATH
County of Clearwater
City of Ahsahka

Registration District No. 90
Primary Registration District No. 2187
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 49

2. FULL NAME Robert L Blevins
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec 25 1849
7. AGE Years 79 Months 3 Days 26 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Missioui

PARENTS
10. NAME OF FATHER Steven Blevins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Mary Long
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virgina

14. Informant Steva Blevins
(Address) Greer Ida
15. Filed 4/22, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 20 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 18th, 1929, to Apr 18, 1929
that I last saw him alive on 4-18-, 1929
and that death occurred, on the date stated above, at 11.30 P.m.
The CAUSE OF DEATH* was as follows:
Flu Pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Valvular Heart Lesion - years -
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) N. R. Hutson M. D.
Apr 25th, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Orofino Ida
Date of Burial April 24 19
20. Undertaker W. A. Shaw
Address Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65827

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
(No.)
Local Registrar's No. 50
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Simpa Savage

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Femal
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Savage
6. DATE OF BIRTH (month, day and year)
7. AGE: Years: About 24; Months; Days; If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): ?

PARENTS
10. NAME OF FATHER: Jack Macey
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ?
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

14. Informant: Nelson Hospital
(Address) Orofino

15. Filed 4/24, 1929. W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1928, to Apr. 23, 1929
that I last saw her alive on April 15, 1929
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis? Sputum examination

(Signed) C. J. Hopkins, M. D.
Apr. 23, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	4/ 1929
20. Undertaker	Address
W. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65828

County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 51

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mae Cooper

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Femal
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Cooper

6. DATE OF BIRTH (month, day and year) March 26 1900

7. AGE: Years 29 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ida

PARENTS

10. NAME OF FATHER Harry Dean
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Inda
12. MAIDEN NAME OF MOTHER Katy Rathbone
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kanas

14. Informant Nelson Hospital
(Address) Orofino Ida

15. Filed 4/26, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 25 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4, 1929, to April 25, 1929
that I last saw her alive on 4/25 1929
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:
Gangrene of Lung

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Flu, Pneumonia, streptococci
..... (duration) ..... yrs. ..... mos. ..... ds.
Premature baby was born Apr 16-1929

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Microscopic-odor
(Signed) N F Robertson M. D.
4/25/, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino Ida | Date of Burial: 4/27 1929

20. Undertaker: W. A. Shaw | Address: Orofino

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65829

PLACE OF DEATH

County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2157
(No. Northern Idaho Sanitarium)
Local Registrar's No. 52
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Samuel S. Linton

(a) Residence. No. ..... St. Lewiston - Idaho -
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 0 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6 DATE OF BIRTH (month, day and year) Unascertained

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	7	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith - retired
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Brunswick

PARENTS
10 NAME OF FATHER Henry L. Linton
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unascertained
12 MAIDEN NAME OF MOTHER Unascertained
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unascertained

14 Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15 Filed 4/25, 1929 W. A. Thain Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 24 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1929, to April 24, 1929, that I last saw him alive on April 23, 1929, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:
General arterio sclerosis
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Psychosis with cerebral arterio-sclerosis (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John Bruce McKelway, M. D.
April 24, 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
W. D. Simson	4/26. 1929
20. Undertaker W. D. Simson Orofino Ida.	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65830

PLACE OF DEATH
County of Clearwater
City of Orofino Idaho

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 53
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dennis Keane
(a) Residence. No. Orofino St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Helen Lawson Keane

6. DATE OF BIRTH (month, day and year) Feb 8 - 1853

7. AGE: Years 76, Months 2, Days 24. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer: ✓

9. BIRTHPLACE (city or town) (State or country): Mukerman

PARENTS
10. NAME OF FATHER: Cornelius Keane
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Mary Monahan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: E. W. Bowdish
(Address)

15. Filed 4/27, 1929. W. A. Shaw, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) — 25th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16th, 1928, to April 26th, 1929
that I last saw him alive on April 25th, 1929
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Nephritis —
..... (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) Valvular heart disease
Pneumonia (duration) 10 yrs. + mos. ..... ds.

18. Where was disease contracted if not at place of death? his home
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Urinal exam Dropsy — Symptoms
(Signed) W. F. Robertson, M. D.
4/27, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fraser — Date of Burial: April 28 1929

20. Undertaker: W. D. Dimson — Address: Orofino

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 6 1929

PLACE OF DEATH

County of Clearwater

City of Orofino

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 2187

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 65831

Local Registrar's No. 54

2. FULL NAME William Henery Shaw

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowd

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 14 1855

7. AGE	Years	Months	Days	If LESS than 1 day,
	79			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Newyork

PARENTS

10. NAME OF FATHER Alexander Shaw

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canida

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Irland

14. Informant Andy Shaw
(Address) Orofino Ida

15. Filed 4/29, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24, 1929, to Apr. 28, 1929, that I last saw him alive on April 28, 1929, and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Bolar pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. J. Hopkins M. D.

Apr. 28, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	May 1 19

20. Undertaker W. A. Shaw Address Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65832

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2107
Local Registrar's No. 55
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John W. VanTine

(a) Residence. No. ..... St. Grangeville - Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ✓ yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) April 4, 1863

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	0	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Placer miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Warren County Illinois

PARENTS

10. NAME OF FATHER Jacob VanTine
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Jersey
12. MAIDEN NAME OF MOTHER Katherine Ann ##
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New Jersey

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed 4/29, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 21, 1929, to April 28, 1929
that I last saw him alive on April 28 1929
and that death occurred, on the date stated above, at 5.57 P. m.
The CAUSE OF DEATH* was as follows:
Primeral arteriosclerosis

(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Psychosis with cerebral arteriosclerosis (duration) ? yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs.

(Signed) Chas Irvine McKelvey, M. D.
April 28, 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Idaho	May 1- 1929
20. Undertaker	Address
W. A. Shaw	Orofino

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65833

PLACE OF DEATH
County of Clearwater
City of Ahsahka

Registration District No. 90
Primary Registration District No. 2157
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 56

2. FULL NAME Gussie Harold Bryant

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1899 March 4th

7. AGE ~~30~~ Years 30 Months 1 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Egger Pole Co

9. BIRTHPLACE (city or town) (State or country) Bellefonte Ark

PARENTS

10. NAME OF FATHER Singleton J. Bryant
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Harrison Ark
12. MAIDEN NAME OF MOTHER Maude Barger
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Singleton J. Bryant
(Address) Ahsahka Ida

15. Filed 4/30, 1929 W A Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21, 1929, to Apr. 30, 1929
that I last saw him alive on April 30, 1929
and that death occurred, on the date stated above, at 10 30 A.m.
The CAUSE OF DEATH* was as follows:
Intestinal Flu
Haemorrhage - bowels
..... (duration) ..... yrs. ..... mos. 15 ds.
CONTRIBUTORY (Secondary) Habits - (years)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms. Microscope
(Signed) N F Robertson, M. D.
5-1, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Cavendish — Date of Burial May 2 1929

20. Undertaker W D Pinson — Address Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 [redacted]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65834

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 57
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma B. Krorzer

(a) Residence. No. ..... St. Harrison, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 73 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wright Krorzer

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day,
	58	?	?	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Unascertained
(State or country)

PARENTS

10. NAME OF FATHER Unascertained
11. BIRTHPLACE OF FATHER (city or town) Unascertained
(State or Country)
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino — Idaho.

15. Filed 4/30, 1929. W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 1, 1926 to April 30, 1929
that I last saw her alive on April 30, 1929
and that death occurred, on the date stated above, at 9:15 A. m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia

..... (duration) 0 yrs. 0 mos. 7 ds.
CONTRIBUTORY (Secondary) Dementia praecox, paranoia
type. (duration) 27 yrs. + mos. + ds.

18. Where was disease contracted ✓ if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John Irvine McKelvey, M. D.
April 30, 1929 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	5/2 1929
20. Undertaker W. A. Shaw	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65835

PLACE OF DEATH

County of Custer
~~City of~~ Ranch on East Fork
Clayton, Idaho

Registration District No. 108
Primary Registration District No. 2186
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 88

2. FULL NAME George Ellis Papworth
(a) Residence. No. Ranch on East Fork St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in ~~city or town~~ Ranch where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Daisy Papworth

6. DATE OF BIRTH (month, day and year): Nov. 9 1876

7. AGE: Years 52, Months 4, Days 5. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer & Stock Raiser
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Ogden Utah

PARENTS

10. NAME OF FATHER: James Robert Papworth
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Emily Martin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. Daisy Papworth
(Address) Clayton Idaho

15. Filed Mar. 29, 1929 Edna McKenney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from was dead before I reached him, 19..., to ..., 19...
that I last saw him alive on ..., 19...
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Probably coronary arteritis (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) C. L. Kirtley, M. D.
Mar. 29, 1929 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clayton, Idaho — Date of Burial: Mar. 17 1929

20. Undertaker: Friends — Address: Clayton, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65836

PLACE OF DEATH
County of Elmore
City of Glenns Ferry

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Irving Judson Pond

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Ethelda Pond

6. DATE OF BIRTH (month, day and year) April 21 1881

7. AGE	Years	Months	Days	If LESS than 1 day,
	47	11	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Physician & Surgeon
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shakopee Minn

PARENTS
10. NAME OF FATHER Samuel V. Pond
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn.
12. MAIDEN NAME OF MOTHER Frances J. Goodrich
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vt.

14. Informant Mrs. V. J. Pond
(Address) 1320 No 8th Apt 1 Boise Idaho

15. Filed , 19 Miss Mary L. Sullivan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on April 3 , 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Overdose of Chloroform taken while in weakened condition following hemmorrhage, Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Isaac E. Hughes Coroner
4-5 , 1929 (Address) Elmore Co.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise Idaho	4-7 1929
20. Undertaker	Address
Schreiber & McCann	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65838

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sophus Sorensen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sina P. Sorensen

6. DATE OF BIRTH (month, day and year) May 8 1962

7. AGE	Years	Months	Days	If LESS than 1 day,
	66	11	2	hrs. or min.

8. OCCUPATION OF DECEASED Laborer
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Peter Benson Sorendon

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Bertha Sorensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Mrs. Dean
(Address) Logan Utah

15. Filed April 13, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/15, 1927, to 4/10, 1929
that I last saw ~~him~~ alive on 4/11, 1929
and that death occurred, on the date stated above, at 6 30 a.m.
The CAUSE OF DEATH* was as follows:
Angina Pectaris
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) E S Bickford, M. D.
4/11, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Glendale Idaho — Date of Burial: Apr. Mar 13 29

20. Undertaker: M. W. Hendricks — Address: Preston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65839

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Millicent Sophia Golightly

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept 12 1857

7. AGE: Years 71 | Months 7 | Days 17 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): housewife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Salt Lake City Ut

PARENTS

10. NAME OF FATHER: Christerfor Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Jacobena Osburn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scottland

14. Informant: Joseph Golightly
(Address): Preston Idaho

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 21, 1929, to Apr 29, 1929, that I last saw her alive on Apr 29, 1929, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(duration) 8 days.

CONTRIBUTORY (Secondary) Carcinoma Uteri
(duration) 1 yrs. 6 mos. 8 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No Clinical
What test confirmed diagnosis?
(Signed) G. W. Stater, M. D.
Apr 30, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho — Date of Burial: May 2 29
20. Undertaker: M. W. Hendricks — Address: Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65840

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Florence Fyrer

2. FULL NAME

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Octu21 1911

7. AGE 17 Years 6 Months 8 Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dewey Utah

9. BIRTHPLACE (city or town) (State or country) W. Fyrer

FARENTS

10. NAME OF FATHER Dewey Utah

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Elverda Anderson

12. MAIDEN NAME OF MOTHER Logan Utah

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Preston Idaho Logan

14. Informant
(Address)

15. Filed , 19 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-1, 1929, to 4-27, 1929
that I last saw her alive on 4-20, 1929
and that death occurred, on the date stated above, at 11:50 p.m.
The CAUSE OF DEATH* was as follows:
Sarcoma of Spine
beginning in Pt Antrum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. R. Cutler, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal M. W. Hendricks Preston Idaho | Date of Burial 19

20. Undertaker M. W. Hendricks | Address

Logan Utah May 3 9 Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65841

PLACE OF DEATH
County of Fremont
City of Teton

Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 271

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Bennett Nelson

(a) Residence. No. Teton Idaho St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mary E. Nelson

6. DATE OF BIRTH (month, day and year) Jan. 27 1865

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	1	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miller
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Joseph N. Nelson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) America

12. MAIDEN NAME OF MOTHER Martha Jane Johnson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) America

14. Informant Mrs Mary E. Nelson
(Address) Teton Idaho

15. Filed 3/24, 1929 W M Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 23rd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) W. M. Hansen Coroner, M.D.
Mar. 23rd, 1929 (Address) St. Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation,~~ or Removal	Date of Burial
Salt Lake City Utah	Mar. 28 1929

20. Undertaker W. M. Hansen Address St. Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65842

RECEIVED MAY 4 1929

PLACE OF DEATH

County of Gem
City of Emmett
Registration District No. 6
Primary Registration District No.
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eva Elizabeth Davis

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	white	widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Thos M. Davis

6. DATE OF BIRTH (month, day and year) Aug 29-1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	7	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marengo Iowa

PARENTS

10. NAME OF FATHER James Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Jerusha Brannen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Raymond M. Davis
(Address) Nelson Alberta

15. Filed 4/21, 1929 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 19, 1929, to Apr 19, 1929
that I last saw her alive on Apr 19, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
From a simple inspection a short time before death my judgement is Chronic Expudative nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) L O Cummings M. D.
4/21, 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	4/21 1929

20. Undertaker C D Bucknum — Address Emmett Idaho

RECEIVED MAY 4, 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65843

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Susan Adair

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	white	married

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of James Adair

6. DATE OF BIRTH (month, day and year) Mar 17 - 1846

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83 2 1	—	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Waynesburg Tennessee

PARENTS

10. NAME OF FATHER Wm Beveridge
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Mary Alexander
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mrs Susie Cozzetto
(Address) Emmett Idaho

15. Filed 4/4, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to Apr 2, 1929
that I last saw her alive on Mar 28, 1929
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. L. Reynolds M. D.
4/4, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Ida	4/4 1929

20. Undertaker C. D. Bucknum — Address Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65844

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No. 6
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lela May Cooper

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Wid
5. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept 9 - 1920
7. AGE: Years 8 | Months 7 | Days 1 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Edgar A. Cooper
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Teresa Stagg
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montana

14. Informant E. A. Cooper
(Address) Emmett Ida
15. Filed 4/11, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 10 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 8, 1929, to Apr 10, 1929
that I last saw her alive on Apr 10, 1929
and that death occurred, on the date stated above, at 8 a m.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
Do not Record
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination of urine
(Signed) E. R. Cummings M. D.
4/11, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 4/12 1929
20. Undertaker: O. D. Bucknum — Address: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65845

PLACE OF DEATH
County of Ada
City of Emmett

Registration District No.
Primary Registration District No.
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace Kelley Harwell

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
fem	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Clarence Harwell

6. DATE OF BIRTH (month, day and year) Nov 22-1910

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18	4	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Emmett
(State or country) Idaho

PARENTS

10. NAME OF FATHER Andrew Kelley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Jessie Horine
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montana

14. Informant Mrs Andy Kelley
(Address) Emmett Ida

15. Filed 4/8, 1929 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to Apr 6th, 1929
that I last saw her alive on Apr 6th, 1929
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Puerperal Sepsis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Pulmonary Tuberculosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J L Reynolds, M. D.
4/8, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	4/8 1929

20. Undertaker C D Buckmann
Address Emmett Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65846

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. 6
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lida Alice Whiteside

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) widow

5a. ~~If married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Thos Whiteside

6. DATE OF BIRTH (month, day and year) Apr 16 - 1874

7. AGE Years 54 Months 11 Days 25 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chillicothe Mo

PARENTS
10. NAME OF FATHER John Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) not known

14. Informant Claude C. Whiteside
(Address) Emmett Idaho

15. Filed 4/12, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 10, 1929, to Apr 11, 1929
that I last saw her alive on Apr 11, 1929
and that death occurred, on the date stated above, at about 8 a m.
The CAUSE OF DEATH* was as follows:
Septic meningitis
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) otitis media (suppurative) (duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) [signature] M. D.
4/12, 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Emmett Idaho
Date of Burial 4/13 1929

20. Undertaker C D Bucknum
Address Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. [illegible] RECEIVED APR 19 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gem

City of Sweet

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6

Primary Registration District No.

(No. , St.)

File No. 65847

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth Mabee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: March (Month) 16 (Day) 1929 (Year)

7. AGE: Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or 20 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Gem Co Sweet Idaho

10. NAME OF FATHER: Roy Ivan Mabee

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Martha Rozella Mervin

13. BIRTHPLACE OF MOTHER (State or Country): Sweet, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed April 18 1929

J L Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/20 to 11:40 P.M. 19 , to Mar 16 - 1929 19 , that I last saw h alive on 19 , and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory (Secondary) Lived 20 minutes.

(Duration) yrs. mos. ds.

(Signed) J L Reynolds M. D.

3/18 1929 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sweet Idaho

DATE OF BURIAL: Mar 17 1929

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65848

PLACE OF DEATH
County of Gooding
City of Gooding

Registration District No. 27
Primary Registration District No.
(No.)
Local Registrar's No. 126

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. **FULL NAME** Herman M Lackey

(a) Residence. No. R F D Gooding Ida
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 12 - 1 - 11

7 AGE — Years: 17 | Months: 4 | Days: 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Oklahoma

PARENTS

10 NAME OF FATHER: Watson Lackey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mo.

12 MAIDEN NAME OF MOTHER: Georgia Newsom

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Helen Lackey
(Address): Gooding Ida

15 Filed 4/30, 1929 J A Cromwell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 15th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1-21-, 1929, to 4-15-, 1929,
that I last saw h[illegible] alive on 4-14-, 1929,
and that death occurred, on the date stated above, at 6, a. m.

The CAUSE OF DEATH* was as follows:

Malignant ends Caroletes

(duration) yrs. mos. 90 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J A Cromwell M. D.
4/30/ 1929 (Address) Gooding Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Gooding Ida — Date of Burial: 4-17 1929

20. Undertaker: A E Thompson — Address: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65849

Local Registrar's No. 125

PLACE OF DEATH
County of Gooding
City of "
Registration District No. 24
Primary Registration District No.
(No. Gooding Hosp.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. **FULL NAME** Dores Lanning

(a) Residence. No. Augusta ave Ida
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of W E Lanning

6 DATE OF BIRTH (month, day and year) 10-10-'09

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10 NAME OF FATHER Tom Brashers
11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know
12 MAIDEN NAME OF MOTHER Maggie Sharp
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ida

14 Informant F. E. Lanning
(Address) Hagerman Ida

15 Filed 4/30, 1929 J H Cromwell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) April (Day) 9 (Year) 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-29, 1929, to 4-9, 1929, that I last saw h[illegible] alive on 4-9, 1929, and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Acute nephritis - Anuresa
Treated

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J H Cromwell M D
4/30 1929 (Address) Gooding Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Gooding Ida	4-11-1929
20. Undertaker A E Thompson	Address Gooding

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65850

PLACE OF DEATH
County of Gooding
City of Gooding
Registration District No. 24
Primary Registration District No.
(No. ....)
Local Registrar's No. 124

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Teresa Frances Smith

(a) Residence. No. .... St. ....
(Usual place of abode)
Length of residence in city or town where death occurred .... yrs. .... mos. .... ds. How long in U. S., if of foreign birth? .... yrs. .... mos. .... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 11-3-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	7	5	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gooding Ida

PARENTS
10 NAME OF FATHER Aaron L. Smith
11 BIRTHPLACE OF FATHER (city or town) (State or country) Iowa
12 MAIDEN NAME OF MOTHER Virginia Waddell
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho

14 Informant A L Smith
(Address) Gooding Ida

15 Filed 4/30, 1929 J H Cromwell
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 8th 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 5, 1929, to 4-8-, 1929, that I last saw her alive on 4-8-, 1929, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Congenital heart disease
atresa pulmonary artery
(duration) 7 yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) ....
(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? ....
Did an operation precede death? No Date of ....
Was there an autopsy? No
What test confirmed diagnosis? ....

(Signed) J H Cromwell M. D.
4/30 1929 (Address) Gooding

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Gooding Ida	4/10/1929

20. Undertaker A E Thompson
Address Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65851

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 16
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward S. Hundevock

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 19 - 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	77	8	27	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oxford Co. Canada

PARENTS

10. NAME OF FATHER Amos Hundevock

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER Mary Stover

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant C A. Hundevock
(Address)

15. Filed 5-4-, 1929 B Chipman
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 1 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1927, to Either March 30 1929
that I last saw h~~im~~ alive on March 30, 1929
and that death occurred, on the date stated above, at 5 9. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis and Interstitial Nephritis
(duration) 3 yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis Heart Condition
(Signed) B Chipman, M. D.
April 3, 1929 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ingersoll Ont. Canada	April 11 1929
20. Undertaker	Address
Bower Mann	Lewiston Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65852

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 2181

Local Registrar's No. 17

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myrtle Birdie Long

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, Divorced (write the word): Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept 28 1882

7. AGE

Years	Months	Days	If LESS than 1 day,
47	6	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Grangeville Idaho

PARENTS

10. NAME OF FATHER: W. N. Yates
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Sarah E. Stewart
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Joseph Yates
(Address) Grangeville, Ida

15. Filed 5-4-, 1929 D. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Gun Shot Wound Head
Suicidal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D. Chipman, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grangeville Idaho
Date of Burial: 4/9 1929

20. Undertaker: E. M. Brown
Address: Juniata, Idaho

RECEIVED JUN 19 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

May 25th, 1929.

Dr. B. Chipman,

Grangeville, Idaho. Re: 65852

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Myrtle Birdie Long who committed suicide April 6th, 1929.

Information DESIRED in order to complete certificate:

Was she SINGLE, MARRIED, WIDOWED or DIVORCED?

PLEASE ANSWER BELOW:

Divorced.

5/30/29. B Chipman

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65853

Local Registrar's No. 18

PLACE OF DEATH
County of Idaho
City of Grangeville
Registration District No. 103
Primary Registration District No. 1001
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Andrew Johnson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Husband Mary

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	11	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS

10. NAME OF FATHER Andrew Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....
12. MAIDEN NAME OF MOTHER Amanda Bond
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn

14. Informant J. E. Johnson
(Address) Grangeville

15. Filed 5-4-, 1929 B Chapman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27, 1929, to April 2, 1929
that I last saw h-- alive on April 2, 1929
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Symptoms & Vomiting
(Signed) B Chapman, M. D.
4-4-, 1929 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville	4-6 1929
20. Undertaker	Address
Bower Ware	Lewiston Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65854

PLACE OF DEATH
County of Idaho
City of Grangeville
Registration District No. 103
Primary Registration District No. 1001
(No. .....)
Local Registrar's No. 20

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Boyd Snodgrass

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 2/9/1913.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	2	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Pomeroy Wash.

PARENTS

10 NAME OF FATHER A. B. Snodgrass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Oklahoma

12 MAIDEN NAME OF MOTHER Blanche Ball

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mo.

14 Informant A B Snodgrass
(Address) Grangeville, Idaho

15 Filed 5-4-, 1929 B Chipman
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 27th 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:
Pulmonary Abscess
.....
.....
(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY Accidental Gun Shot
(Secondary)
wound
(duration) ..... yrs. 4 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Dec 27-29
Was there an autopsy? No
What test confirmed diagnosis? Rontgen - Lung.
(Signed) B Chipman M. D.
4/27, 1929 (Address) Grangeville, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Pomeroy, Wash.	
20. Undertaker	Address
Brower - Wamble	Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65855

PLACE OF DEATH

County of Idaho.
City of Whitebird.
Registration District No. 103
Primary Registration District No. 2181
Local Registrar's No. 19
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sherman Cornwell.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1869.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60.	----	----	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER Andrew Cornwell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Not known.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant D. A. Hardin
(Address) RR Whitebird, Idaho.

15. Filed 5-4-, 1929. B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 27th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22, 1929, to April 27, 1929, that I last saw h~~im~~ alive on April 27, 1929, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH was as follows: Lobar Pneumonia

(duration) yrs. mos. 9 ds.
CONTRIBUTORY (Secondary) Empyema & injury to Lung
fractured Skull
(duration) yrs. mos. 10 ds.
18. Where was disease contracted if not at place of death? accidental Rock Slide
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Consolidated Lung.
(Signed) B. Chipman, M. D.
4/28/29., 19 (Address) Grangeville, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	4/29/29. 19

20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65856

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 10
Primary Registration District No. 2184
Local Registrar's No. 170

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Edwin Schwartz

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 5 1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kooskia - Idaho

PARENTS

10. NAME OF FATHER Henry Schwartz
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Hattie Emerson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant Henry Schwartz
(Address) Kooskia - Idaho

15. Filed March 18, 1929 J M Eberhardt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:
No medical Attendant
Premature birth 7 mos

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J M Eberhardt M. D.
March 18, 1929 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Tahor Cemetery	March 18 1929
20. Undertaker	Address

RECEIVED APR 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65857

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Idaho
City of Harpster

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 271

2. FULL NAME Viola May Blankenship

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day and year)

7 AGE: Years | Months | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harpster Ida

PARENTS
10 NAME OF FATHER: Samuel McCully Blankenship
11 BIRTHPLACE OF FATHER (city or town) (State or country): Morton Wash.
12 MAIDEN NAME OF MOTHER: Ruby May Hunter
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Texas

14 Informant: Samuel McCulley Blankenship
(Address) Riggins Idaho

15 Filed April 1, 1929 J M Verberkuers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. (Month) 24 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows: Lived 11 days then went to sleep and didnt wake up - Mother nearly burned to death in Oct 1928
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) No doctor at birth
Turned black just before it died ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H W Wentworth, M. D.
Feb 25, 1929 (Address) Stites

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Harpster Ida
Date of Burial: Feb 26 1929

20. Undertaker: None
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 2 RECEIVED MAY 4 1929 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jerome
City of Jerome
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18
Primary Registration District No.
(No. , St.)

File No. 65858
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eugene Perry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct 29 1880 (Month) (Day) (Year)

7. AGE: 48 yrs. 4 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Frank Perry

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Julia Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed 3/29 1929 Chas F Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar 28 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 28 1929, to Mar. 28 1929, that I last saw h[illegible] alive on Mar. 28 1929, and that death occurred on the date stated above, at 2:50 P.M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. A. Zeller M. D.
19 (Address) Jerome, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Idaho. DATE OF BURIAL 191

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MINIMUM RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED MAY 4 1929

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Jerome

City of Jerome

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18

Primary Registration District No.

(No. , St.)

File No. 65859

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John J Griffiths

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH: July (Month) 23 (Day) 1866 (Year)

63

7. AGE: 63 yrs. 4 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John J Griffiths

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Eleanor Lloyd

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Floyd Griffiths

(Address) Jerome Idaho

15.

Filed 3/6 1929 Chas F Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept — 1928, to Mar. 5 1929 that I last saw him alive on Mar. 5 1929 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

~~Carcinoma Bowel~~

apoplexy

Cardio-Vascular-Renal Disease

(Duration) yrs. 9 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. F. Zeller M. D.

19 (Address) Jerome, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Idaho

DATE OF BURIAL: Mar. 8 1919

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED MAY 1 1929

1. PLACE OF DEATH. Registration District No. 18

County of ..... Primary Registration District No. .....

File No. 65860

City of ..... (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuels S Reed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 27 (Day) 1897 (Year)

7. AGE: 31 yrs. 8 mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Conn.

10. NAME OF FATHER: Samuel S Reed

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Adora Bangley

13. BIRTHPLACE OF MOTHER (State or Country): Rhode Island

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adnes Reed

(Address) Jerome

15. Filed 4/1 1929 Chas F Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29, to Mar. 30 29, that I last saw h alive on Mar. 30 29, and that death occurred on the date stated above, at 5:40 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Bowel

(Duration) ..... yrs. 9 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Zeller M. D.

19..... (Address) Jerome Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Idaho. DATE OF BURIAL ..... 191..

20. UNDERTAKER ..... ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 20M-1-16-12

RECEIVED MAY 4 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 65861

Registered No.

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

County of Jerome

City of Jerome (No. , St.)

If death occurred away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Della Lola Jensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W	Child

6. DATE OF BIRTH: Feb. (Month) 23 (Day) 19 (Year)

7. AGE: 2 yrs. 1 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Jerome Idaho

10. NAME OF FATHER Alvord Jensen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Lola Ostler

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alvord Jensen
(Address) Jerome Idaho.

15. Filed 3/27 1929 C. F. Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 1st 1929, to Mar. 27 1929, that I last saw her alive on Mar. 27 1929, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Cerebro-Spinal Meningitis
Pneumococcus infection

(Duration) yrs. mos. 27 ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. ds.

(Signed) C. F. Zeller M. D.
3/27 1929 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED MAY 4 1929

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jerome
City of Jerome
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18
Primary Registration District No.
(No. , St.)

File No. 65862
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rulon W. Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	

6. DATE OF BIRTH: Feb. (Month) 12 (Day) 1929 (Year)

7. AGE: yrs. 1 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Jerome, Idaho

10. NAME OF FATHER Rulon Cox

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Blenda Turpin

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rulon Cox
(Address) Jerome, Idaho

15. Filed 3/28 1929 Chas F. Zeller Jnc Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 25 1929, to Mar. 27 1929
that I last saw him alive on Mar. 25 1929
and that death occurred on the date stated above, at 1 P M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) yrs. mos. 7 ds.
Contributory (Secondary) —
(Duration) yrs. mos. ds.
(Signed) Chas. F. Zeller M. D.
3/28 1929 (Address) Jerome, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~ Jerome | DATE OF BURIAL ..... 191..

20. UNDERTAKER — | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12 RECEIVED MAY 4 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 18
County of Jerome — Primary Registration District No.
City of Jerome (No. , St.)
File No. 65863
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nannie Agnes Blamires

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Infant

6. DATE OF BIRTH: Feb. (Month) 28 (Day) 1929. (Year)

7. AGE: ..... yrs. ..... mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Jerome Jerome.

10. NAME OF FATHER Laurence B Blamires

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Cuilla E Morgan.

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Laurence B Blamires
(Address) Jerome Idaho.

15. Filed March 13 1929 Chas F Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/26 1929, to ..... 191 ,
that I last saw her alive on 2/26 1929
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Preture mature Infant
Asthenia due to
non development
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Zeller M. D.
19 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Inc.

RECEIVED MAY 4 1929

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18.

County of Gooding

Primary Registration District No.

City of Jerome.

(No. R.R.4. St.)

File No. 65864

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Burgoyne.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married. (Write the word.)

6. DATE OF BIRTH: July (Month) 29 (Day) 1866 (Year)

7. AGE: 62 yrs. 5 mos. 4. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota.

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grant Burgoyne.

(Address) R.R.4. Jerome. Idaho.

15.

Filed 1/12 1929 Chas F Zeller Jr. C. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1926, to Jan 3 1929 that I last saw her alive on Dec 24 1929 and that death occurred on the date stated above, at 59 M.

The CAUSE OF DEATH*, was as follows:

Myocarditis, apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Myocarditis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) John F. Schmerstall M. D.

Jan 5 1929 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Idaho

DATE OF BURIAL: Jan. 5 1929

20. UNDERTAKER: A. E. Thompson

ADDRESS: Gooding Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED MAY 4 1929

Form V. S. No. 5 20M.1-16-12 **CERTIFICATE OF DEATH**

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 65865

Registered No.

1. **PLACE OF DEATH.**

Registration District No. 16

County of Jerome

Primary Registration District No.

City of Jerome (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Ellen S Griffiths

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** (Write the word.) Married

6. **DATE OF BIRTH** ..... (Month) ..... (Day) 1840 (Year)

7. **AGE** 88 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. **OCCUPATION**

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Mattson Co Ill

10. **NAME OF FATHER** Louis W. Leonard

11. **BIRTHPLACE OF FATHER** (State or Country) Virginia

12. **MAIDEN NAME OF MOTHER** Martha Penney

13. **BIRTHPLACE OF MOTHER** (State or Country) Dont Know

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) R H Griffiths

(Address) Jerome

15.

Filed 4/30/ 1929 Chas F Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH** Jan (Month) 29 (Day) 1929 (Year)

17. **I HEREBY CERTIFY,** That I attended deceased from Jan 1 1929, to Jan 29 1929, that I last saw her alive on Jan 28 1929, and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

General Asthenia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Zeller M. D.

2/1 1929 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Jerome Cemetery | **DATE OF BURIAL** Jan 31 1929

20. **UNDERTAKER** D A Harrison | **ADDRESS** Jerome

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MAY 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65869

PLACE OF DEATH
County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No.
(No. Wendell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME John B. Leichliter

(a) Residence: No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. John B. Leichliter

6. DATE OF BIRTH (month, day and year)

7. AGE Years: 64 Months: 6 Days: If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Self

9. BIRTHPLACE (city or town) (State or country): Penn

PARENTS

10. NAME OF FATHER: J. W. C. Leichliter
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Mary Brooks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn

14. Informant: Mrs Thursey Leichliter
(Address) Jerome Ida

15. Filed Jan 18, 1927 Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

205-B

16. DATE OF DEATH: Jan. (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to Jan. 17, 1929
that I last saw him alive on Jan. 17, 1929
and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:
Internal Haemorrage
Rupture of Liver, Inferior
Posterior surface
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 1/16/29
Was there an autopsy? yes
What test confirmed diagnosis? Rent in Liver
(Signed) Chas. F. Zeller M. D.
1/17, 1929 (Address) Jerome, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery
Date of Burial: 4 19

20. Undertaker: White Mortuary
Address: Twin Falls

RECEIVED JUL 1 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, ORofino
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

May 25, 1929.

Dr. Chas. F. Zeller,

Jerome, Idaho.

Re: 65869

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

John B. Leichliter who died January 17, 1929.
You gave as cause of death: "Internal Hemorrhage. Rupture of liver, Superior Posterior posterior surface".

Information DESIRED in order to complete certificate:

Please advise as to the cause of the rupture, etc.

PLEASE ANSWER BELOW:

Fell during epileptic attack
Traumatism external surface of body
over liver causing rent of liver.

Form V. S. No. 5 20M.1-16-12 RECEIVED MAY 4 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Jerome

Primary Registration District No.

File No. 65871

City of Jerome (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James H Sears

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

70 yrs. mos. ds.

IF LESS than 1 day how many hrs. or mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work Lumber Foreman

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Michagan

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H A Sears

(Address) Jerome

15.

Filed 1/31 1929 Chas F Zeller

Jme Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1929, to Jan 27 1929, that I last saw him alive on Jan 27 1929 and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Chronic Myocardeter
acute Heart Failure

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas F. Zeller M. D.

4/1 1929 (Address) Jerome, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jerome Cemetery	1/30 1929
20. UNDERTAKER	ADDRESS
H A L Harrison	Jerome Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

IMMEDIATELY UPON RECEIPT OF THIS CERTIFICATE, THE REGISTRAR SHOULD STAMP IT WITH THE DATE OF FILING AND SIGN HIS NAME AS SHOWN.

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED MAY 4 1929

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Jerome

Primary Registration District No.

File No. 65873

City of Jerome (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Hepkin Lodge

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Infant

6. DATE OF BIRTH

April (Month) 11 (Day) 1929 (Year)

7. AGE

..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many *H. D. hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Jerome

10. NAME OF FATHER Melvin Lodge

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Gertrud Andreasen

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Melvin Lodge

(Address) Jerome Idaho

15.

Filed 4/12 1929 Chas F Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature Undeveloped Infant Twin.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Zeller M. D.

4/12 1929 (Address) Jerome Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 191...
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65876

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 65

2. FULL NAME William Mackey
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) 1858-9-30
7. AGE Years 70 Months 6 Days 13 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Nekimi. Wis
PARENTS
10. NAME OF FATHER W. Mackey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Margret Webster
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland
14. Informant Mrs. Rosa Marshall
(Address) Tacoma W.
15. Filed Apr 25, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 13 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 4, 1929, to April 13, 1929
that I last saw him alive on April 12, 1929
and that death occurred, on the date stated above, at 1.20 A. m.
The CAUSE OF DEATH* was as follows:
Pelvic carcinoma?
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Alexander Barclay, M. D.
4-13-, 1929 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene — Date of Burial 4-14 1929
20. Undertaker Cassedy Funeral Home — Address C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65877

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. 1)
Local Registrar's No. 64

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harry B. O'Brien

(a) Residence. No. 1705 Mullan Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 12 1907

7. AGE	Years	Months	Days	If LESS than 1 day,
	21	9	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Boiler
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Russell
(State or country) North Dakota

PARENTS

10. NAME OF FATHER L. S. O'Brien
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn
12. MAIDEN NAME OF MOTHER Samantha Henderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn

14. Informant D. P. O'Brien
(Address) Coeur d'Alene Ida

15. Filed Apr 25, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December, 1928, to April, 1929
that I last saw h[illegible] alive on April 14th, 1929
and that death occurred, on the date stated above, at 10:20 A m.
The CAUSE OF DEATH* was as follows:
Tubercular Meningitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Tubercular knee & Tubercular epididymitis
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes no Date of Dec. 12, 1928
Was there an autopsy?
What test confirmed diagnosis? Examination
(Signed) Harold J. Sturges, M. D.
4/16, 1929 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hartline, Wn.	4/18 1929

20. Undertaker F B Mooney Address Pullman

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65878

Local Registrar's No. 67

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene
Province of Quebec

Registration District No. Kootenai 30
Primary Registration District No. 1058

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph La Frontaine

(a) Residence No. R.F.D. No 1 Coeur d'Alene Ida
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Leonida La Fontaine

6. DATE OF BIRTH (month, day and year) 1849 - 2 - 22

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	1	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Cacina, Quebec, Canada

PARENTS

10. NAME OF FATHER — La Fontaine
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER — Estaire —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant P. A. La Fontaine
(Address) Coeur d'Alene Idaho

15. Filed Apr 25, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 16th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1929, to Apr 16, 1929
that I last saw him alive on Apr 16th, 1929
and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Throat & tongue
(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Examination & Symptoms

(Signed) T. L. McCauley, M. D.
Apr 17, 1929 (Address) Post Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Thomas Cem. CdAlene	4-18 1929
20. Undertaker	Address
Cassedy Funeral Home	CdAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED MAY 7 1929

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65879

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 62

2. FULL NAME Ray Sharbono
(a) Residence: No. 316 - Coeur d'Alene Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1929 - 4 - 23

7. AGE Years Months Days 1 day If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho

PARENTS
10. NAME OF FATHER Sylvester Sharbono
11. BIRTHPLACE OF FATHER (city or town) Todd Co. Minn.
(State or Country)
12. MAIDEN NAME OF MOTHER Carrie Holler
13. BIRTHPLACE OF MOTHER (city or town) Minn.
(State or Country)

14. Informant Mrs Wm Robeson
(Address)

15. Filed Apr 25, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-23-, 1929, to 4-23, 1929
that I last saw him alive on 4-23, 1929
and that death occurred, on the date stated above, at 8 45 A.m.
The CAUSE OF DEATH* was as follows:
Probable Asphyxia.
Probable Asthenia of heart.
(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) E.H. Teed, M. D.
4-25-, 1929 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene Ida
Date of Burial 4-25 1929

20. Undertaker Cassedy General Home
Address C D Alene.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65880

Local Registrar's No. 61

2. FULL NAME Martha K Albright

(a) Residence. No. 408 Military drive St. Hutchinson Kans
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 12, 1853

7. AGE Years 75 Months 9 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Jones Mills Penn

PARENTS

10. NAME OF FATHER John Cook

11. BIRTHPLACE OF FATHER (city or town) (State or Country) U S

12. MAIDEN NAME OF MOTHER Still

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) U S

14. Informant Mrs Sam Dishnart
(Address) Coeur d'Alene, Ida

15. Filed Apr 25, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan., 1929, to Apr. 20, 1929

that I last saw her alive on Apr 19, 1929

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of gall bladder

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Kansas

Did an operation precede death? Yes Date of Apr. 3 1929

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Operation

(Signed) J. C. Dwyer M. D.

Apr. 20, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hutchinson Kans

Date of Burial 4/21 1929

20. Undertaker R B Mooney

Address Coeur d'Alene

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65881

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 60

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Caroline Waddell

(a) Residence. No. — Rathdrum, Idaho
(Usual place of abode)
Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Male~~ Female
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: John Waddell
6. DATE OF BIRTH (month, day and year): March 17. 1835
7. AGE: Years 93 | Months 11 | Days 20 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Kingsport Tenn.

PARENTS
10. NAME OF FATHER — Ketron
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn.
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown Tenn.

14. Informant: Mrs. Sally Cowley
(Address): Rathdrum, Idaho

15. Filed Apr 8, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 9. 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feby 20. 1929, to March 9. 1929
that I last saw h.r alive on March 9. 1929
and that death occurred, on the date stated above, at 4.30 a.m.
The CAUSE OF DEATH* was as follows:
Acute Broncho-Pneumonia
(duration) ..... yrs. ..... mos. 9. ds.
CONTRIBUTORY (Secondary) Epidemic Influenza
(duration) ..... yrs. ..... mos. 21 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Frank Sturges, M. D.
3/18. 1929 (Address) Rathdrum, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pine Grove Cemetery — Date of Burial: 3-11- 1929
20. Undertaker: Cassedy Funeral Home — Address: Rathdrum

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

City of Worley, Ida. (No. ..... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Selp. W. Thompson.

If death occurred in hospital, institution give its NAME street and number

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Sep - (Month) 17th (Day) 1900. (Year)

7. AGE: 28 Yrs. 7 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: See Laborer.

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Randolph. Neb.

10. NAME OF FATHER: Jasper. N. Thompson

11. BIRTHPLACE OF FATHER (State or Country): Jasper Co. Iowa.

12. MAIDEN NAME OF MOTHER: Miss Jane Warfield

13. BIRTHPLACE OF MOTHER (State or Country): Logan Co. Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs May M Thompson Mother

(Address) Grand Forks B. C.

15. Filed 4/9 1929 H. J. Sturges Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 2nd (Day)

17. I HEREBY CERTIFY, That I attended deceased March 28th 1929, to April 2nd that I last saw him alive on April 2nd and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Flu and Double Pneumonia

..... (Duration) ..... Yrs. ..... mos.

Contributory (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos.

(Signed) J. J. Herrington

Apr 3 1929 (Address) Worley Ida

*State the Disease Causing Death; or in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Worley Ida

DATE OF BURIAL: Apr. 3

20. UNDERTAKER: [signature]

ADDRESS: Plummer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65883

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1051
Local Registrar's No. 59

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Roscoe E. Young.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Henrietta A. Young.

6. DATE OF BIRTH (month, day and year) Jan. 10 1870

7. AGE Years 59 Months 2 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Banker.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS
10. NAME OF FATHER Stewart Young.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Sarah Colgrove
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Henrietta A. Young
(Address) Rathdrum, Ida.

15. Filed Apr 9, 1929 H J Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24, 1929, to March 26, 1929
that I last saw him alive on March 26, 1929
and that death occurred, on the date stated above, at 8.30 a. m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris.

..... (duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Frank Wenz, M. D.
3/28, 1929 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial
Pace Abbey Fairmont Cemetery Spokane Wash 3/29 1929

20. Undertaker Cassedy Funeral Home Address Rathdrum

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65884

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1051
Local Registrar's No. 57

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Juanita Faith Ward

(a) Residence. No. Spring Water add. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Oct 20, 1928

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	5	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho

PARENTS

10. NAME OF FATHER Geo T. Ward
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colo
12. MAIDEN NAME OF MOTHER Goldie Jumper
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Geo T. Ward
(Address) Coeur d'Alene Ida

15. Filed Apr. 10, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1928, to April 10, 1929
that I last saw her alive on April 8, 1929
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Congenital Myatonia
(duration) ..... yrs. 5 mos. 19 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Examination

(Signed) Harold J. Sturges, M. D.
April 10, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	4/10 1929
20. Undertaker R B. Mooney	Address C d A Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65885

PLACE OF DEATH

County of Latah
City of Viola

Registration District No. 61
Primary Registration District No. 2141
(No.)
Local Registrar's No. 20

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. **FULL NAME** Lydie T. Smith

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sidney T. Smith

6 DATE OF BIRTH (month, day and year) Oct. 7, 1842

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
8 6	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bruce county
(State or country) Mich.

PARENTS

10 NAME OF FATHER Jefferson Teller

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Margaret Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Maud A. Blair
(Address) Viola, Idaho

15 Filed 4-9, 1929 W. H. Carruthers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 9/ (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,
that I last saw h alive on , 19 ,
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Found dead in bed.
Death probably due to
acute myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) F. R. Short Coroner, M. D.
4/9, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Viola	4/11 1929
20. Undertaker F. R. Short	Address Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65886

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No.)

Local Registrar's No. 21

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Hubert B. Mickey

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of Agnes Mickey
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec? 11, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Insurance agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Blairstown Iowa

PARENTS

10 NAME OF FATHER Martin S. Mickey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Martin S/ Mickey
(Address) Moscow, Idaho

15 Filed 4-12, 1929 W. H. Carithers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
April 11, 1929
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1929 to April 11, 1929
that I last saw him alive on April 11, 1929
and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditas

(duration) 4 D. yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Carithers M. D.

4/12 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Moscow
Date of Burial: 4/14/29 19

20. Undertaker: E. R. Short
Address: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65887
Local Registrar's No. 27

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 1011
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME ELIAS HANSEN

(a) Residence. No. St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Hanna Ellisor

6 DATE OF BIRTH (month, day and year) May 13 1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	11	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS
10 NAME OF FATHER Hans Christian
11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant W. C/ Rhodes
(Address)

15 Filed 5/1, 1929 W H Carruthers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 29 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1929 to April 29, 1929
that I last saw h[illegible] alive on April 29, 1929
and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:
Myocarditis
Chronic prostatic hypertrophy.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical.
(Signed) C. C. Armstrong M. D.
4/30/ 1929 (Address) Moscow Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of ~~Burial, Cremation,~~ or Removal: Date of Burial 19
Short Lake Minn.
20. Undertaker F. R. Short Address Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65888

PLACE OF DEATH

County of Latah
City of Moscow

CERTIFICATE OF DEATH

Registration District No. 101
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 26

2. **FULL NAME** Mary Lathrop

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: T.F. Lathrop

6 DATE OF BIRTH (month, day and year): Aug. 19, 1853

7 AGE: Years 75 | Months 8 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Monroe Wis.

PARENTS
10 NAME OF FATHER: Jessie Wood
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio
12 MAIDEN NAME OF MOTHER: Hester Wood
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Oral Lathrop
(Address): Moscow, Idaho

15. Filed 4-25, 1929 W H Carthers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 23, 1929 (Month) (Day) 19.... (Year)

17 I HEREBY CERTIFY, That I attended deceased from 2-1, 1929, to 4-23, 1929, that I last saw her alive on April 23, 1929, and that death occurred, on the date stated above, at 3:30 p m.

The CAUSE OF DEATH* was as follows: sequella of influenza and old age senility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) W M Hatfield V.O. M.D.
4/25/ 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Moscow
Date of Burial: 4/25/29 19

20. Undertaker: F. R. Short
Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65889

PLACE OF DEATH

County of Latah
City of Moscow

CERTIFICATE OF DEATH

Registration District No. 101
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 25

2. FULL NAME Cra Ovenia De Young

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M. De Young

6 DATE OF BIRTH (month, day and year) May 5, 1870

7 AGE: Years 59, Months 11, Days 17 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hiawatha Kansas

PARENTS
10 NAME OF FATHER Jacob Oberholtzer
11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.
12 MAIDEN NAME OF MOTHER Martha Bremer
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kan.

14 Informant M. DeYoung
(Address) Moscow, Idaho

15 Filed 4-23, 1929 W. H. Carothers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 22, 1929 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1929, to April 22, 1929, that I last saw her alive on April 22, 1929, and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:
Bronchial pneumonia
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza. Myxadema.
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical.
(Signed) C. Cannthony, M. D.
4/23, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Pullman Wash — Date of Burial: 4/24 1929

20. Undertaker: H. R. Short — Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65890

PLACE OF DEATH

County of Latah
City of Moscow

CERTIFICATE OF DEATH

Registration District No. 101
Primary Registration District No. 1011
(No.) Local Registrar's No. 24
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Frederick Lawerance Busch

(a) Residence. No. St. Colton, Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct 1 1927

7 AGE: Years 1 | Months 6 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Colton Wash.

PARENTS
10 NAME OF FATHER Christofer Busch
11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash.
12 MAIDEN NAME OF MOTHER Louise Grieser
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ida.

14 Informant C.M. Busch
(Address) Colton, Wash.

15 Filed 4-19, 1929 W.H. Carithers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 18, 1929 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1929, to April 18, 1929, that I last saw him alive on April 17, 1929, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:
Adynamic ileus.
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hemiotomy. Anaemia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of Apr 16 1928
Was there an autopsy? No
What test confirmed diagnosis? Clinical signs.
(Signed) [signature], M. D.
4/19/ 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Cloton, Wash.
Date of Burial: 4/20/29 19

20. Undertaker: H. R. Short
Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65891

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 101
Primary Registration District No. 1011
(No.)
Local Registrar's No. 23
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Evelyn Juliett Mercer

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) April 4, 1911

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18		13	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bone Gap
(State or country) Ill.

PARENTS
10 NAME OF FATHER Charley L. Mercer
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ill.
12 MAIDEN NAME OF MOTHER Chloie Hocking
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant C.L. Mercer
(Address) Moscow, Idaho

15 Filed M-18, 1929 W.H. Gaarithers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 17, 1929
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1929, to April 17, 1929, that I last saw her alive on April 15, 1929, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH*, was as follows:
Acute pulmonary tuberculosis.

(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical signs.
(Signed) [illegible], M. D.
4/18, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Moscow	4/19/29
20. Undertaker	Address
E. R. Short	Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65892

Local Registrar's No. 19

PLACE OF DEATH

County of Latah
City of Moscow
Registration District No. 101
Primary Registration District No. 1011
(No. Inland Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Laura Vanslyke

(a) Residence. No. ____ St. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb. 17, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	56	1	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newton county Mo.

PARENTS
10 NAME OF FATHER John H. Vanslyke
11 BIRTHPLACE OF FATHER (city or town) (State or country) Mo.
12 MAIDEN NAME OF MOTHER Not known
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Emma Dilley
(Address) 2626 1/2 Jefferies ST., Los Angeles

15 Filed M-5, 1929 W. H. Walters Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 3, 1929 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1929, to April 3, 1929, that I last saw her alive on April 3, 1929, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: Cardio-renal disease & dropsy

(duration) ____ yrs. 7 mos. ____ ds.

CONTRIBUTORY (Secondary) Pul Edema

(duration) ____ yrs. ____ mos. 2 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. D. Magee M. D.
4/5, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow	4/5/29

20. Undertaker F. R. Short — Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65893

PLACE OF DEATH

County of Latah

City of Moscow

CERTIFICATE OF DEATH

Registration District No. 101

Primary Registration District No. 101

(No. Gutman Hospital)

Local Registrar's No. 18

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME CLYDE EARL LUTHER

(a) Residence. No. ..... St. Troy Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb. 25 - 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
6	I	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Moscow Idaho

PARENTS

10 NAME OF FATHER Howard Luther

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lewville, Ill.

12 MAIDEN NAME OF MOTHER Anne Friske

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hoffman Minn.

14 Informant Howard Luther
(Address) Troy Idaho

15 Filed April 2, 1929 W. H. Carithers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 1 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1929, to April 1, 1929, that I last saw him alive on April 1, 1929, and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:
Convulsions, due to infection of ear.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Infected ear. Mastoiditis.

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 31 1929

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) [signature] M. D.

4/4, 1929 (Address) Moscow Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow Ida	4/4/29 19

20. Undertaker	Address
H. R. Short	Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65894

PLACE OF DEATH
County of Latah
City of Helmer
Registration District No. 64
Primary Registration District No. 2144
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alma Wolfbrandt
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Conrad Wolfbrandt

6. DATE OF BIRTH (month, day and year) Jan 21 - 1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	61	2	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER — Jethberg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER not-Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Conrad Wolfbrandt
(Address) Helmer Ida

15. Filed April 30 19 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6, 1929, to April 12, 1929, that I last saw h[illegible] alive on April 10, 1929, and that death occurred, on the date stated above, at 5 P. m. The CAUSE OF DEATH* was as follows: Bronchopneumonia.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? [illegible]
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Thos. F. Meyer M. D.
April 12, 1929 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow Idaho	April 14 1929
20. Undertaker	Address
John J. Pickerd	Troy Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65895

PLACE OF DEATH
County of Latah
City of Troy
Registration District No. 64
Primary Registration District No. 2144
(No. ....)
Local Registrar's No. ....
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Netta Belle Cummings

(a) Residence. No. .... St. ....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Chas Cummings

6. DATE OF BIRTH (month, day and year) Nov 12 1873

7. AGE	Years	Months	Days	If LESS than 1 day,
	55	5	11	.... hrs. or .... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Ezekiel Reed
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Alvira Wright
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ....

14. Informant Mrs Melvin Effi
(Address) Troy Idaho

15. Filed April 30, 1929 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 22, 1929, to Apr 23, 1929,
that I last saw h[illegible] alive on Apr 22, 1929
and that death occurred, on the date stated above, at .... m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis
(duration) 3 yrs. .... mos. .... ds.
CONTRIBUTORY (Secondary) ....
(duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? No Date of ....
Was there an autopsy? No
What test confirmed diagnosis? ....
(Signed) Chas. A. Meyer M. D.
Apr 25, 1929 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow Idaho	April 26 1929
20. Undertaker	**Address**
John J. Pickard	Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65896

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James E Browning

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 27, 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52.	11	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER E. N. Browning.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " " " "

14. Informant A Browning
(Address) Potlatch Ida.

15. Filed March 2nd, 1929 J. Jr. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25th, 1929, to March 2nd, 1929
that I last saw him alive on Feb 27th, 1929
and that death occurred, on the date stated above, at 10 a.m.
The CAUSE OF DEATH* was as follows:

Acute Influenzal pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Jr. Thompson, M. D.
3/2/, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal — Date of Burial
Cruzen Cem March 4 1929

20. Undertaker — Address
E. H. Irwin Palouse Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 19 1929

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65897

PLACE OF DEATH
County of Latah
City of Princeton

Registration District No. 65
Primary Registration District No. 2145
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Fredrick Johnston
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sep 15 1870

7. AGE: 58 Years, Months 5, Days 16. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer): Woods Department
(c) Name of employer: Pottlatch Lum Co

9. BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS
10. NAME OF FATHER: F. Johnston
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: F. A. Lienhard
(Address): Princeton Ida.

15. Filed March 2nd, 1929. D. Jr. Thompson, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 2 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1st, 1928, to March 2nd, 1929 that I last saw him alive on Feb. 26th, 1929 and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Hip

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) F. C. Erbien, M. D.
3/2/, 1929 (Address) Pottlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Palouse Wash. Date of Burial: March 3 1929

20. Undertaker: E. H. Drum. Address: Palouse

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65898

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Henry L. Wysong

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July 21 - 1847

7. AGE: Years 81 | Months 8 | Days 17 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Elizabeth Mizel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: H. L. Wysong
(Address): Palouse Wash

15. Filed April 10th 1929. J. Jon Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Apr. 8, 1929, to —, 19—, that I last saw him alive on Apr 8 1929 and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart
— (duration) — yrs. — mos. — ds.
CONTRIBUTORY (Secondary): Acute indigestion
— (duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) E. K. Wolf M. D.
Apr 9, 1929 (Address) Palouse, Wn.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ellopica Wash	April 11 1929
20. Undertaker E. M. Brown	Address Palouse Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 19 1929

PLACE OF DEATH

County of Latah

City of Pottatch

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65899

Registration District No. 65.

Primary Registration District No. 2145.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert James Willett

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER William J. Willett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn

12. MAIDEN NAME OF MOTHER Whiting

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spokane Wash

14. Informant Mrs. William J. Willett
(Address) Bovill, Idaho.

15. Filed April 4th, 1929. J. M. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 4th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29th, 1929, to April 4th, 1929 that I last saw him alive on April 4th, 1929 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Shock (surgical) following operation for imperforate rectum (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Manitou. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes. Date of March 30th

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) F. C. Gibson, M. D.

April 4th, 1929 (Address) Pottatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal Palouse Wash Date of Burial Apr 4 1929

20. Undertaker F. M. Irwin Address Palouse Wash

RECEIVED MAY 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

County of Latah

City of Genesee

CERTIFICATE OF DEATH 62

Registration District No.

Primary Registration District No. 2142

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65900

Local Registrar's No.

2. **FULL NAME** John Alber

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth 40 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of Elizabeth Alber
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan. 23-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Common laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Alber ~~Not known~~

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ~~"~~ Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~~"~~

14 Informant Mrs. Susan Alber

(Address) Genesee, Ida.

15 Filed 4-8-, 1929 W. T. Eblen
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 7, 1929
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr. 6, 1929, to Apr 7, 1929, that I last saw h~~e~~ alive on Apr 7, 1929, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Auto Accident

(duration) 10 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Diagnosis Symptoms

(Signed) W. T. Eblen M. D.

4-9-, 1929 (Address) Genesee

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Genesee

Date of Burial: 4/9/29 19

20. Undertaker: [illegible]

Address: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65901

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Not Named Infant

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): March 12-29

7. AGE: Years | Months | Days 5 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Salmon Idaho

PARENTS

10. NAME OF FATHER: Lee Akins
11. BIRTHPLACE OF FATHER (city or town) (State or Country): S Carolina
12. MAIDEN NAME OF MOTHER: Emma Gravely
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): S Carolina

14. Informant: Lee Akins
(Address): Salmon, Idaho

15. Filed April 17, 1929 Chas Billamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 17th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12, 1929, to March 15, 1929
that I last saw him alive on 15, 1929
and that death occurred, on the date stated above, at 11-8 m.
The CAUSE OF DEATH* was as follows:
congenital debility -

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) Chas F Hammer, M. D.
Apr 15, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery | Date of Burial: 3/18/1929

20. Undertaker: Wm C Doehler | Address: Salmon Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65902

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Joseph Edward Sanderson
(a) Residence No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): —
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): March 3rd 1929
7. AGE: Years | Months 1 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Salmon Idaho

PARENTS
10. NAME OF FATHER: Jerry Sanderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Margaret Arizona
12. MAIDEN NAME OF MOTHER: Anna Romeriz
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Colorado

14. Informant: Jerry Sanderson
(Address): Salmon, Ida.
15. Filed April 17, 1929 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 15th 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 13, 1929, to April 15, 1929
that I last saw him alive on April 15, 1929
and that death occurred, on the date stated above, at 4-8 m.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia
..... (duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? Baker, Idaho
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) [illegible], M. D.
April 16, 1929 (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery | Date of Burial: 4-16th 1929
20. Undertaker: [illegible] | Address: Salmon Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65903

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME William B. Hart

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie M. Hart

6. DATE OF BIRTH (month, day and year) July 10 1867

7. AGE 61 Years Months 9 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Pharmacist
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Morris, Ill.

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Philip J Sherron
(Address) Salmon, Idaho.

15. Filed April 17, 1929. Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to April 11, 1929 that I last saw him alive on April 10, 1929 and that death occurred, on the date stated above, at 5.00 A.m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) Bratton, M. D.
4/13, 1929 (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery — Date of Burial: 4-13-1929

20. Undertaker: Wm C Doebler — Address: Salmon, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65904

PLACE OF DEATH

County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Florance Elizbeth Porter
(a) Residence. No. Salmon Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE: 10 Month 1928 Years; Months: July; Days: 3rd; If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Denver Colorado

PARENTS
10. NAME OF FATHER Jack D. Porter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fresno California
12. MAIDEN NAME OF MOTHER Bessie E Mann
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Weiser Idaho

14. Informant Jack D Porter
(Address) Salmon Idaho

15. Filed April 10, 1929 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 25th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 24, 1929 March 25, 1929
that I last saw her alive on Mar 24, 1929
and that death occurred, on the date stated above, at 4-30 A.m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) R. Stratton, M. D.
3/27", 1929 (Address) Salmon, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery — Date of Burial: 3-27th 1929
20. Undertaker: Wm C. Doebler — Address: Salmon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65905

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 50
Primary Registration District No. 2179
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

2. FULL NAME Anna Mae Booth
(a) Residence. No. St. Culdesac Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): 6/1/1915
7. AGE: 13 Years, Months: 10, Days: 14. If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Culdesac Idaho

PARENTS
10. NAME OF FATHER: Ed Booth
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Oregon.
12. MAIDEN NAME OF MOTHER: Clara Mortimore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wash

14. Informant: Ed Booth
(Address): Culdesac, Idaho.
15. Filed 4/17, 1929 R. A. Dunlap Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) - 15 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April - 12, 1929 to April - 15, 1929
that I last saw her alive on April - 15, 1929
and that death occurred, on the date stated above, at 12 15 a. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary): Endocarditis Mercurius
(duration) 2 yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) John F. Gist, M. D.
April - 15, 1929 (Address) Winchester Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Culdesac, Idaho — Date of Burial: 4/16 1929
20. Undertaker: Brown-Wurm Co. — Address: Lewiston Idaho

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65906

PLACE OF DEATH
County of Madison
City of Salem

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 30
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Laura Pearl Virgin

(a) Residence. No. Salem Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 28 - 19[illegible]8

7. AGE: Years 1 | Months | Days 5 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salem Idaho

PARENTS

10. NAME OF FATHER Hyrum Charles Virgin

11. BIRTHPLACE OF FATHER (city or town) (State or Country) St Charles Bear Lake Co. Idaho

12. MAIDEN NAME OF MOTHER Eleanor Eliza Kingsley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St Charles Bear Lake Co. Idaho

14. Informant Freeho Charles Virgin
(Address) Salem Idaho

15. Filed May 7, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 3, 1929
that I last saw h[illegible] alive on May 1, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Coronary Thrombosis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Otitis media
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) R. B. Kingsbury, M. D.
May 6, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sugar City Cemetary	May 5th 19
20. Undertaker ALVIN KELLER	Address REXBURG

Alvin Keller

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65907

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 31

2. FULL NAME George Stoddard

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day and year): March 30 - 29

7 AGE: — Years — Months — Days — If LESS than 1 day, 1 hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rexburg Idaho

PARENTS
10 NAME OF FATHER: Floyd Stoddard
11 BIRTHPLACE OF FATHER (city or town) (State or country): Beaver Canyon Idaho
12 MAIDEN NAME OF MOTHER: Ruby Muir
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hibbard Idaho

14 Informant: Floyd Stoddard
(Address): Rexburg Idaho

15 Filed May 4, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 30 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Birth, 1929, to March 30, 1929, that I last saw him alive on March 30, 1929, and that death occurred, on the date stated above, at 11:0 m.

The CAUSE OF DEATH* was as follows: (Cerebral Hemorrhage) Baby was born, cried, breathed then after a few minute stopped breathing. Heart beat for an hour.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): unknown
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) H. B. Rigby M. D.
May 4, 1929 ~~(Address)~~ Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Sugar City
Date of Burial: 4-2 1929

20. Undertaker: A. B. Eckersell
Address: Rexburg

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65908

PLACE OF DEATH

County of Madison

City of Rexburg

CERTIFICATE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 32

2. FULL NAME Ralph Stephen Hunt

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, ~~or Divorced~~ (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 20, 1869

7 AGE: Years 59 | Months 8 | Days 28 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer & Stock Grower

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): West Weber Utah

PARENTS

10 NAME OF FATHER: Ralph Hills Hunt.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poughkeepsie New York.

12 MAIDEN NAME OF MOTHER: Sarah Skelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pottsville Penn.

14 Informant: Griffith Williams

(Address) Rexburg Idaho.

15 Filed 4/9, 1929 J Ryan Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 8 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1929, to April 8, 1929, that I last saw him alive on April 8, 1929, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH was as follows:

Embolism. (coronary)

5 hours

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Intestinal obstruction (mechanical)

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? Yes Date of April 6-1929

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & findings

(Signed) Lorin F Rich M. D.

4-9-, 1929 (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of ~~Burial, Cremation,~~ or Removal: Ogden Utah

Date of Burial: 19

20 Undertaker: A B Eckersell West Weber Cemetery

Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65909

PLACE OF DEATH

County of Madison
City of Rexburg

CERTIFICATE OF DEATH

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 33

2. FULL NAME Harold George Romrell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan 8, 1913

7 AGE: 16 Years, Months 3, Days 3 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Sugar City, Idaho.

PARENTS
10 NAME OF FATHER: Lorenzo J. Romrell
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ogden Utah
12 MAIDEN NAME OF MOTHER: Emma Eggertz
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Logan Utah

14 Informant: Lorenzo J. Romrell
(Address) Sugar City Idaho.

15 Filed 4/13, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 11 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1929, to April 11, 1929, that I last saw him alive on April 11, 1929, and that death occurred, on the date stated above, at 3:40 A m.

The CAUSE OF DEATH* was as follows:
Peritonitis
(general diffuse-septic)
..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary): gangrenous appendicitis
..... (duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? Place of death
Did an operation precede death? Yes Date of April 6-1929
Was there an autopsy? No
What test confirmed diagnosis? findings
(Signed) Louis I. Kirk M. D.
4-13, 1929 (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Sugar City Cemetery — Date of Burial: 4/15 1929

20. Undertaker: A B Eckersell — Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65910

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Madison
City of Sugar City

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 34

2. FULL NAME Gladys Georgia Ricks

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug. 20, 1913

7 AGE: Years 15 | Months 7 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Sugar City Idaho.

PARENTS
10 NAME OF FATHER: Dennis H. Ricks
11 BIRTHPLACE OF FATHER (city or town) (State or country): Rexburg Idaho.
12 MAIDEN NAME OF MOTHER: Hazel Garner
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sugar City Idaho.

14 Informant: Dennis Ricks
(Address): Sugar City Idaho.

15 Filed 4/13, 1929 J Ryong Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 12 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to April 12, 1929, that I last saw her alive on April 11, 1929, and that death occurred, on the date stated above, at 4:00 a.m.

The CAUSE OF DEATH* was as follows:
Cerebro-Spinal Meningitis
Epidemic Type
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Catarrhal Jaundice
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) H S Rigby M. D.
April 13, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Sugar City Cemetery
Date of Burial: 4/13 1929

20. Undertaker: A B Eckersell
Address: Rexburg

RECEIVED MAY 10 19..

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65911

PLACE OF DEATH

County of Madison
City of Rexburg

CERTIFICATE OF DEATH

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
Local Registrar's No. 35

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME LeRoy Patten Brown

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Hazel Smith Brown

6 DATE OF BIRTH (month, day and year) Sept 27, 1890

7 AGE: 38 Years, Months 7, Days 22. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Plano Idaho

PARENTS
10 NAME OF FATHER: Joseph S. Brown
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ogden Utah
12 MAIDEN NAME OF MOTHER: Sarah Wealthy Patten
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Payson Utah

14 Informant: Mrs Hazel Brown
(Address) Rexburg R.F.D. #3

15 Filed 4/22, 1929 J Ryonng Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 19 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1929, to April 19, 1929, that I last saw him alive on April 19, 1929, and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:
Nephritis
(interstitial chronic)
(duration) ..... yrs. ? mos. ..... ds.

CONTRIBUTORY (Secondary) Rupture of small intestine (kick from a horse).
(duration) ..... yrs. ..... mos. 12 ds.

18 Where was disease contracted if not at place of death? Place of death
Did an operation precede death? Yes Date of April 7-1929
Was there an autopsy? No
What test confirmed diagnosis? Findings & Laboratory
(Signed) Louis F Rich, M. D.
April 22, 1929 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Plano Ida
Date of Burial: 19

20. Undertaker: C B Eckersell
Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65912

PLACE OF DEATH
County of Madison
City of Sugar City

CERTIFICATE OF DEATH
Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 36

2. FULL NAME Emma Emelia Ricks

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Willard Ricks

6 DATE OF BIRTH (month, day and year): Feb. 10, 1861

7 AGE: 68 Years, Months 2, Days 17 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Brigham City Utah

PARENTS
10 NAME OF FATHER: Rassmuss N. Jeppson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Denmark
12 MAIDEN NAME OF MOTHER: Emma Emelia Bravent
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Denmark

14 Informant: R. N. Jeppson
(Address) Rexburg Idaho

15 Filed 4/27, 1929 J. Ryoung Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 27 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from January, 1929, to April 24, 1929, that I last saw her alive on April 24, 1929, and that death occurred, on the date stated above, at 5:17 m.

The CAUSE OF DEATH* was as follows: Carcinoma of breast

..... (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Pulmonary metastasis

..... (duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & findings

(Signed) Rowe F. Rich, M. D.
4-27, 1929 (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rexburg Cemetery
Date of Burial: 4/29 1929

20. Undertaker: C. B. Eckersell
Address: Rexburg

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65913

PLACE OF DEATH

County of Butte
City of Hawe

CERTIFICATE OF DEATH

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 37

2. FULL NAME Richard Grant Winmill

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day and year): Feb. 24, 1926

7 AGE: Years 3 | Months 2 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Sugar City Idaho

PARENTS
10 NAME OF FATHER: Joseph Winmill
11 BIRTHPLACE OF FATHER (city or town) (State or country): Utah
12 MAIDEN NAME OF MOTHER: Ethel M. Mathie
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wayne Wyoming

14 Informant: Mrs Ethel Winmill
(Address): Sugar City Idaho

15 Filed 4/30, 1929 J. Ryong Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 28 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Post Mortem, 19..., to Coll, 19...
that I last saw h..... alive on ....., 19...
and that death occurred, on the date stated above, at 1 P.M. m.
The CAUSE OF DEATH* was as follows:
Accidental drowning
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): fall into creek
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) Louis F. Rich M. D.
4-30, 1929 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Sugar City Cemetery
Date of Burial: 4/30 1929

20. Undertaker: C. B. Eckersell
Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 4 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19 F

Primary Registration District No. 2015

(No. ....., ... St.)

File No. 65914

Registered No. 24

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary C Bradshaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: April (Month) 22 (Day) 1853 (Year)

7. AGE: 75 Yrs. 11 Mos. 13 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Hans Jensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rhoda Hyde

(Address) Rupert Idaho

15. Filed 4-6 1929 E H Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17 1929, to April 4 1929 that I last saw her alive on April 4 1929, and that death occurred on the date stated above, at 3 15/p. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar Bilateral

(Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) Valv. Heart disease, Mitral Insufficiency (Duration) About 20 yrs. ..... mos. ..... ds.

(Signed) Leland Frazier M. D.

4-6 1929 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah

DATE OF BURIAL: Apr 7 1929

20. UNDERTAKER: W. A. Goodman

ADDRESS: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAY 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65915

PLACE OF DEATH
County of Minedoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2010
Local Registrar's No. 25
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Donald H Gransbury
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) April 6 1929
7. AGE Years Months Days 6 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Rupert Ida

PARENTS
10. NAME OF FATHER Orvil H Gransbury
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Albion Ida
12. MAIDEN NAME OF MOTHER Blanch M Cole
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho Falls Ida

14. Informant O. H. Gransbury
(Address) Rupert Ida
15. Filed 4-12, 1929 E H Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 12 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr. 6, 1929, to Apr. 12, 1929
that I last saw him alive on Apr. 12, 1929
and that death occurred, on the date stated above, at 11 15 8 m.
The CAUSE OF DEATH* was as follows:
Incomplete closure of Foramen Ovale
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) E H Elmore M. D.
5-2, 1929 (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Paul Ida
Date of Burial April 13 1929
20. Undertaker D. E. Johnson
Address Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

D D Clarke

DO NOT WRITE IN THIS SPACE
State File No. 65916

Local Registrar's No.

Registration District No. 95
Primary Registration District No. 1009

PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. East Lewiston)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alfred P. Baker,
(a) Residence. No. 6 Lewiston St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Jan 26 1926

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	1	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home,
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS
10. NAME OF FATHER Claus Baker.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holland.
12. MAIDEN NAME OF MOTHER Lillian Chen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Holland.

14. Informant Claus Baker
(Address) Lewiston Idaho.

15. Filed Ap 8, 1929 April 8 29 Registrar
Timm & Bru

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 1 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 27, 1929 to Mar. 1, 1929
that I last saw him alive on Mar 1, 1929,
and that death occurred, on the date stated above, at 1145 P. M.
The CAUSE OF DEATH* was as follows: Influenza
Pneumonia.
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? None
What test confirmed diagnosis? Surgical Signs & Symp.

(Signed) D D Clarke DO
Mar 1, 1929. (Address) 305-8 Brin Bldg, Lewiston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho.	3/2 1929
20. Undertaker	Address
Nassar Mortuary	Lewiston Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65917

PLACE OF DEATH

County of Nezperce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Lillian Melinda Bucholz

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charley Bucholz

6. DATE OF BIRTH (month, day and year) Feb. 10, 1886

7. AGE	Years	Months	Days	If LESS than 1 day,
	43		21	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Balsam Lake, Wis

PARENTS

10. NAME OF FATHER Fred Sittkus
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Medora Blodgett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Charley Bucholz
(Address) Asotin, Wash.

15. Filed Apr 8, 19.... Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from (Feb 28, 1929, to 3-4—, 1929
that I last saw h.. alive on 3-4—, 1929
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:
Uraemia — (Chronic Nephritis)
(duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) Chronic Nephritis Interstitial
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. White, M. D.
3-5- 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Asotin, Wash	3/3/29 19

20. Undertaker H.R.Merchant Address Clarkston Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Scott.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65918

PLACE OF DEATH
County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Calvin LaGrand Murphy.

(a) Residence. No. 1105 Snakeriver Avenue. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 6/24/1916.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
12.	8.	8.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School boy.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Emmett, Idaho.

PARENTS

10. NAME OF FATHER John F. Murphy.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Terra Haute. Indiana.
12. MAIDEN NAME OF MOTHER Teha Franshu.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Quebeck, Canada.

14. Informant Mrs Bert Leyde
(Address) Lewiston, Idaho.

15. Filed 4/8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 2nd, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1929, to March 3, 1929
that I last saw him alive on Mar. 3, 1929
and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:
Paratyphoid Fever
(duration) yrs. mos. 2 6 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Lewiston Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Widal Test
(Signed) R-T Scott, M. D.
3/4/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	3/4/29. 19
20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

Hab. L.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65919

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. 1725 Main Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Frederick Kenfield.

(a) Residence. No. 1725 Main Street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 6/30/1846.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82.	8.	2.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Attorney.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hastings, Michigan.

PARENTS

10. NAME OF FATHER Hiram J. Kenfield.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.

12. MAIDEN NAME OF MOTHER Polly Ingraham.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant Mrs W. F. Kenfield.
(Address) Lewiston, Idaho.

15. Filed Apr 8, 1929 Susan E. Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 2nd, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1929, to March 2, 1929, that I last saw h[illegible] alive on March 2, 1929, and that death occurred, on the date stated above, at 10 30 p. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured hip.

(duration) yrs. mos. 16 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no What test confirmed diagnosis? Physical Signs

(Signed) Wilfred Hatfield, M. D.
3/5/29., 19. (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	3/6/29. 19

20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

May 25th, 1929.

Dr. Wm. P.H. Habel,

Lewiston, Idaho. Re: 65919

RECEIVED MAY 30 1929

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

William Frederick Kenfield who died March 2nd, 1929.
You gave as the cause of death: "Hypostatic Pneumonia".
Contributory cause: "Fractured hip"

Information DESIRED in order to complete certificate:

What KIND OF AN ACCIDENT was the primary cause of death.
If an automobile accident advise whether it occurred within the city limits or on the highway.

PLEASE ANSWER BELOW:

Patient slipped in bath tub striking hip against edge of tub.

W.P.H. Habel

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65920

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Morton Strong.

(a) Residence. No. County farm. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73.			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Patient county farm.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tipton, Ohio.

PARENTS

10. NAME OF FATHER ------- Strong.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Mrs E. Downs
(Address) Lewiston, Idaho.

15. Filed Apr 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 4th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1929 to Mar 4, 1929
that I last saw h[illegible] alive on Mar 4, 1929
and that death occurred, on the date stated above, at 10 30 a.m.
The CAUSE OF DEATH* was as follows: Cancer of gall bladder

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. R. Tyle, M. D.
3/6/29, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	3/6/29. 19
20. Undertaker	**Address**
Brower-Vann Company.	Lewiston, Idaho.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65921

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucio Amunategui

(a) Residence. No. St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male | 4. COLOR OR RACE White | 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE | Years 29 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shepherder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Anton Urangoa

9. BIRTHPLACE (city or town) (State or country) Arrasua, Spain

PARENTS

10. NAME OF FATHER Mr. Amunategui

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spain

12. MAIDEN NAME OF MOTHER Peten Gandarias

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spain

14. Informant Anastasio Goyo Boise
(Address)

15. Filed Apr 8, 1929 Susan E Prine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Gun Shot wound
in head
Suicide
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C M Brown Coroner
3/7, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Boise, Idaho | Date of Burial 19

20. Undertaker Brown Mortuary Co | Address Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No.

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. 5th, and Main streets.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucoi Amonatogui.

(a) Residence. No. St. Boise, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32.			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sheep herder.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dobbins & Huffman.

9. BIRTHPLACE (city or town) (State or country) Not known.

PARENTS

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant L. P. Brown.
(Address) Lewiston, Idaho.

15. Filed Apr 8, 1929 Susan E. Brune Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 6th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Gun shot Wound to head. Suicide.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Earl Brown Coroner M. D.
3/7, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise, Idaho	19

20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED APR 12 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65922

County of Nez Perce.
City of Lewiston.
Registration District No. 95
Primary Registration District No. 1009
Local Registrar's No.
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David McFarland.

(a) Residence. No. (Usual place of abode) St. Lapwai, Idaho. (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nancy Powakee McFarland.

6. DATE OF BIRTH (month, day and year) 1871.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58.			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10. NAME OF FATHER Enoch McFarland.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.
12. MAIDEN NAME OF MOTHER Mary Wapsheli.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Nancy McFarland.
(Address) Lapwai, Idaho.

15. Filed Apr 8, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 12th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7, 1929, to March 12, 1929
that I last saw him alive on March 12, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
acute perforated appendicitis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) peritonitis
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Mar 7 29
Was there an autopsy? yes
What test confirmed diagnosis?
(Signed) W O Clark, M. D.
3/14/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spalding, Idaho.	3/15/29. 19
20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho

RECEIVED APR 12 1929

Braddock

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65923

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. 802 4th, Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Tolbert Wenstrum.

(a) Residence. No. 802 4th, St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 9/30/1917.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
11.	5.	15.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Debbs, Minnesota.

PARENTS

10. NAME OF FATHER J. T. Wenstrum.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden.

12. MAIDEN NAME OF MOTHER Ingabo Osland.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden.

14. Informant J. T. Wenstrum
(Address) Lewiston, Idaho.

15. Filed Ap 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 15th, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to March 15, 1929
that I last saw him alive on March 14, 19
and that death occurred, on the date stated above, at 12 P. m.
The CAUSE OF DEATH* was as follows:

Cerebrospinal meningitis
(Meningococcus)

(duration) yrs. 3 mos. 4 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam spinal fluid

(Signed) E G Braddock, M. D.

3/18/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	3/18/29. 19

20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Broddock

DO NOT WRITE IN THIS SPACE
State File No. 65924

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. 1156 12th, Avenue.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Gustave Vönnigerholz/

(a) Residence. No. 1156 12th, Avenue. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1/14/1862.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67.	2.	2.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Custodian City Hall.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) San Francisco,
(State or country) California.

PARENTS

10. NAME OF FATHER George Vönnigerholz.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Germany.

12. MAIDEN NAME OF MOTHER Mary Elizabeth Netzel.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Germany.

14. Informant Mrs C. G. Vönnigerholz
(Address) Lewiston, Idaho.

15. Filed Apr 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 16th, 1929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from
March 15, 1929, to March 16, 1929
that I last saw him alive on March, 1929
and that death occurred, on the date stated above, at 10 30 P m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) E. E. Broddock, M. D.
3/18/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	3/19/29. 19

20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 1 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Stocksleger

DO NOT WRITE IN THIS SPACE

State File No. 65925

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

(No. 1851 9th, Avenue.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ingmund Horsaeth.

(a) Residence. No. 1851 9th, Avenue. St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 21st, 1929.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
------	1.	25.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston,
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Ingmund Horseath.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Norway.

12. MAIDEN NAME OF MOTHER Betty Cunneen.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Canada.

14. Informant Mrs. Ingmund Horseath
(Address) Lewiston, Idaho.

15. Filed Apr 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 16th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16, 1929, to March 16, 1929
that I last saw him alive on March 16, 1929
and that death occurred, on the date stated above, at 10:30 a. m.
The CAUSE OF DEATH* was as follows:

Pronchopneumonia.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? At home.
Did an operation precede death? No Date of none
Was there an autopsy? No
What test confirmed diagnosis? none

(Signed) H B Stocksleger, M. D.
3/17/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	3/17/29. 19
20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

Born 12/21/28 Z #6

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65926

Local Registrar's No.

PLACE OF DEATH

County of Lewiston
City of Nez Perce

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ann L Jones

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 16 1837

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	91	9	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Dand Caley.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Catherine Collins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Susty Madaline
(Address) Lewiston Idaho

15. Filed Apr 8, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 11, 1929, to Mch 18, 1929
that I last saw her alive on Mch 18 1929
and that death occurred, on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
8 days.
(duration) yrs. mos. ds.
CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Paul D Johnson M. D.
3/19, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Minneapolis Minn	19
20. Undertaker	Address
Bass & Mortuary	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

Lyle.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65927

Registration District No. 95
Primary Registration District No. 1009
Local Registrar's No.

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isaac H. Truesdall.

(a) Residence. No. County farm. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not known.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75.			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Patient county farm.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not known.

PARENTS

10. NAME OF FATHER Not known.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.

12. MAIDEN NAME OF MOTHER Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant W. H. Kirkman.
(Address) Lapwai, Idaho.

15. Filed Apr 8, 1929. Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 18th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14, 1929, to Mar 18, 1929
that I last saw h[illegible]live on Mar 18, 1929
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows: Myocarditis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. H. Lyle, M. D.
3/19/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	3/20/29. 19

20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65928

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George W. King.

(a) Residence. No. St. Lapwai, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	Married.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Edith King.

6. DATE OF BIRTH (month, day and year) 9/23/1877.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51.	5.	27.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Dayton,
(State or country) Washington.

PARENTS

10. NAME OF FATHER Thomas King.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.
12. MAIDEN NAME OF MOTHER Nancy Bounds.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon.

14. Informant Mrs G. W. King.
(Address) Lapwai, Idaho.

15. Filed Apr 8, 1929 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 20th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 17, 1929 to Mar 20, 1929 that I last saw him alive on Mar 20, 1929 and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:
Peritonitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Perforated gastric Ulcer (duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 3/17/29
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W O Clark, M. D.
3/21/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	3/24/29. 19

20. Undertaker Brower-Mann Company. Address Lewiston, Idaho.

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65929

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. 2118 12th, Avenue.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank W. Watson.

(a) Residence. No. 2118 12th, Avenue. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 19th, 1870.

7. AGE Years: 58. Months: 9. Days: 3. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kings Valley, Oregon.

PARENTS

10. NAME OF FATHER: W. N. Watson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Springfield, Illinois.

12. MAIDEN NAME OF MOTHER: Sarah Chambers.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kings Valley, Oregon.

14. Informant: Henry Watson
(Address) Lewiston, Idaho.

15. Filed Ap 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 22nd, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 18th, 1929, to Mar 22nd, 1929 that I last saw him alive on Mar 22nd, 1929 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Dilatation of Heart
(duration) yrs. + mos. ds.

CONTRIBUTORY (Secondary) Hypertension Nephritis
(duration) + yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Heart Examination

(Signed) O C Learsow, M. D.

3/23/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 3/25/29. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Johnson.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65930

PLACE OF DEATH
County of Nezperce
City of Lewiston
Registration District No. 95
Primary Registration District No. 1009
(No. N-Lewiston)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Harriett Josephine Simpson

(a) Residence. No. N-Lewiston St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 5 1929

7. AGE

Years	Months	Days	If LESS than 1 day,
~~2~~	~~2~~	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston (State or country) Idaho.

PARENTS

10. NAME OF FATHER F. M. Simpson
11. BIRTHPLACE OF FATHER (city or town) Adams (State or Country) Oregon
12. MAIDEN NAME OF MOTHER Flora Lupinacci
13. BIRTHPLACE OF MOTHER (city or town) Spokane (State or Country) Wash.

14. Informant Frances M. Simpson
(Address) Lewiston Idaho

15. Filed Apr 8, 1929 Simon E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 22, 1929, to Mch 23, 1929
that I last saw her alive on Mch 22, 1929
and that death occurred, on the date stated above, at 1a m.
The CAUSE OF DEATH* was as follows: Broncho pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Paul E. Simpson M. D.
3/23, 1929 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho — Date of Burial: 3/24 1929

20. Undertaker: Vassar Mortuary — Address: Lewiston Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65931

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sam Caffile Jr.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 3/27/29

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or
				30 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston Idaho
(State or country)

PARENTS

10. NAME OF FATHER Frank Caffile
11. BIRTHPLACE OF FATHER (city or town) Italy
(State or Country)
12. MAIDEN NAME OF MOTHER Helen Meyers
13. BIRTHPLACE OF MOTHER (city or town) Neb.
(State or Country)

14. Informant Frank Caffile
(Address) Lewiston

15. Filed Apr. 8, 1929 Susan E. Brun
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27, 1929, to March 27, 1929
that I last saw him alive on March 27, 1929
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? "
Did an operation precede death? no Date of "
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) E. G. Broderick, M. D.
March 28, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho.	3/28 1929

20. Undertaker Vassar Mortuary Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65932

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Paffile Jr.

(a) Residence. No. N Lewiston St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 3/27/29

7. AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Frank Paffile
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Helen Meyers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ger.

14. Informant Frank Paffile Sr
(Address) N Lewiston

15. Filed Apr 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 27, 1929, to Mar 27, 1929
that I last saw h alive on Mar 27, 1929
and that death occurred, on the date stated above, at 1130 P m.
The CAUSE OF DEATH* was as follows:

Premature birth
6 mos gestation
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) E A Broadbent, M. D.
Mar 28, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho.	Mar 29 1929

20. Undertaker Vassar Mortuary Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65933

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 95
Primary Registration District No. 1009
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard Peterson
(a) Residence. No. Spalding Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Indian	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Oct 9 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	5	23	

8. OCCUPATION OF DECEASED —
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Orofino Ida

PARENTS
10. NAME OF FATHER Tom Petterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Asotin
12. MAIDEN NAME OF MOTHER Clara Contraro
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Snohomish Wash.

14. Informant Tom Petterson
(Address) Lapwai Idaho

15. Filed Apr 8, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 2nd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29th, 1929, to Apr 2nd, 1929, that I last saw him alive on Apr 2nd, 1929, and that death occurred, on the date stated above, at m
The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Dust Bron
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Lung condition
(Signed) O. L. Pearson, M. D.
Apr 2nd, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spalding Ida	4/3 1929
20. Undertaker H R. Merchant	Address Clarkston Wash

Spaldings is in Dist 95

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65934

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME John Dalbury
(a) Residence. No. 718-Bridge Clarkston St. Clarkston Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept 3 - 1914
7. AGE Years 24 Months 6 Days 2 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Wis

PARENTS
10. NAME OF FATHER Chris Dalburg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wis
12. MAIDEN NAME OF MOTHER Hannah Siemenian
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wis

14. Informant Mrs Thomas Scarbyning
(Address) 718 Bridge St Clarkston

15. Filed May 10, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 5 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 4, 1929, to Apr 5, 1929
that I last saw him alive on Apr 5 1929, 19
and that death occurred, on the date stated above, at 10:15 P.M.
The CAUSE OF DEATH* was as follows:
Gunshot wound of Brave self administered.
Suicidal
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Clarkston wash
Did an operation precede death? yes Date of Apr 4 1929
Was there an autopsy? yes
What test confirmed diagnosis? none
(Signed) E G Broadock, M. D.
Apr 6, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 4/8 1929
20. Undertaker Vassar Morleaux
Address Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65935

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. St Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Jabeth Ellamwood

(a) Residence. No. Sweetwater Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 13 1929

7. AGE Years — Months 10 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lapwai Idaho

PARENTS

10. NAME OF FATHER James Ellamwood

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spaulding

12. MAIDEN NAME OF MOTHER Elizabeth Crowe

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spaulding Sweetwater Idaho

14. Informant James Ellamwood
(Address) Sweetwater

15. Filed Ap 16, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3, 1929, to April 8, 1929.

that I last saw him alive on April 8, 1929.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) William R. Habel, M. D.

4/8/29, 19 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sweetwater Idaho — Date of Burial 4/9 1929

20. Undertaker Vassar Mortuary Lewiston Idaho — Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65936

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 0117 — 24th St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Louis L. Shurty
(a) Residence. No. 0117 — 24th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 12/25/1855

7. AGE Years 73 Months 3 Days 28 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Newark N. J.

PARENTS

10. NAME OF FATHER Louis Shurty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Anan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs L. L. Shurty
(Address) Lewiston, Idaho

15. Filed May 10, 1929 Emma E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 13th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1929, to April 13, 1929
that I last saw him alive on April 13, 1929
and that death occurred, on the date stated above, at 5 p. m.
The CAUSE OF DEATH* was as follows:
Gangrene - feet.
(duration) yrs. mos. 15 ds.
CONTRIBUTORY (Secondary) Endarteritis.
(duration) yrs. 8 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Phys. col. signs
(Signed) William P. H. Hobel, M. D.
4/15, 1929 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho. Date of Burial: 4/15/29 19
20. Undertaker: Brower - Wann Co Address: Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65937

PLACE OF DEATH

County of Nezperce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. St. Joseph Hospital)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joe Bittle Frick

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Chile

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): June 6, 1924

7. AGE: Years 4, Months 10, Days 8. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Clarkston, Wash.

PARENTS

10. NAME OF FATHER: George E Frick

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Portland, Ore.

12. MAIDEN NAME OF MOTHER: Nelle M Bittle

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana,

14. Informant: George E Frick

(Address): Clarkston, Wash.

15. Filed May 10, 1929 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 14 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9, 1929, to April 14, 1929, that I last saw him alive on April 14, 1929 and that death occurred, on the date stated above, at 6 50 p. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac - dilatation.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Septicaemia - Mastoid

(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of March 18-1929

Was there an autopsy? no

What test confirmed diagnosis? Laboratory findings

(Signed) William P. H. Haber, M. D.

4/17, 1929 (Address) Lewiston - Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Ida. Date of Burial: 4/17/29 19

20. Undertaker: H. R. Merchant Address: Clarkston Wn

Bradley's

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65938

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Daniel J. Dunham

(a) Residence. No. St. Kooskia, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred Dunham

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	3	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Paw Paw Ohio

PARENTS

10. NAME OF FATHER H. Dunham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Cathrine Crosd
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Columbus Ohio

14. Informant Mildred L Dunham
(Address) Kooskia Ida

15. Filed May 10, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 14th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12, 1929, to April 14, 1929
that I last saw him alive on April 14, 1929
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:

Acute appendicitis
Gangrenous
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Acute Peritonitis
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? Kooskia Idaho
Did an operation precede death? Yes Date of April 12 1929
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) E G Bradford M. D.
April 23, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kooskia Ida. Dunhams private cemetary	April 16 1929

20. Undertaker	Address
Geo. H. Freeny	Kooskia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PLACE OF BIRTH should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PLACE OF DEATH

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65939

County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.

(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Axel Erickson

(a) Residence. No. 1123 12th st St. Clarkston Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 29 1902

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	10	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Mill Work
(c) Name of employer Clearwater Timber Co.

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER E.M. Erickson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Johanna Lindberg
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Harold Lindberg
(Address) Coeur D Alene Idaho

15. Filed May 10, 1929 Emma E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12, 1929, to April 15, 1929
that I last saw him alive on April 15, 1929
and that death occurred, on the date stated above, at 9:15 P.m.
The CAUSE OF DEATH* was as follows:
General Peritonitis following ruptured appendix

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of April 13
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) R.T. Scott, M. D.
, 19 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Coeur D Alene Idaho	
20. Undertaker Vassar Mortuary	Address Lewiston Ida.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65940

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 961

Primary Registration District No. 1009

Local Registrar's No.

(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Della Ingram

(a) Residence. No. Orofino Idaho St. Oro fino Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Ingram

6. DATE OF BIRTH (month, day and year): Nov. 29 1897

7. AGE: Years 31, Months 4, Days 17. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Peck Idaho

PARENTS

10. NAME OF FATHER: L.D. Parsons

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Cora Axtell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Larkin Parsons
(Address) Elk River Idaho

15. Filed May 10, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr 16 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6, 1929, to Apr 15, 1929 that I last saw her alive on Apr 15, 1929 and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows: Chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. M. Lyle, M. D.

4-16 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho
Date of Burial: 4/17/29 19

20. Undertaker: Vassar Mortuary
Address: Lewiston Ida

TION is very important. See instruction on back of certificate.

Carson

RECEIVED MAY 13 1929

PLACE OF DEATH

County of Nez Perce

City of Lewiston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65941

Registration District No. 95

Primary Registration District No. 1009

Local Registrar's No.

(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Candis Harriett Leon

(a) Residence. No. Lewiston Orchards St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 61 Months 7 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Ira Parker

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Rachel Strong

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Albert Leon
(Address) Lewiston Orchards

15. Filed May 10, 1929 Susan E Brune Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April, 20. 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 22nd, 1929, to April 20th, 1929 that I last saw her alive on April 20th, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Toxemia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Carcinoma of Stomach

(duration) yrs. + mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X ray pictures

(Signed) O C Carson, M. D.

4/22/29, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Cemetery — Date of Burial: Ap 23 1929

20. Undertaker: Brown Van Waren — Address: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65942

PLACE OF DEATH
County of NezPerce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Herman J Keisecker

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 2, 1909

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	1	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Anatone, Wash.

PARENTS

10. NAME OF FATHER John G. Keisecker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mary Kraus
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant John G Keisecker
(Address) Anatone, Wash.

15. Filed 4-21, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-18, 1929, to 4-21, 1929
that I last saw him alive on 4-21, 1929
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:

Acute Appendicitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of 4-18-29
Was there an autopsy? no
What test confirmed diagnosis? Operation

(Signed) J.M.McElvain, M. D.
4/21, 1929 (Address) Clarkston Wash

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clarkston Wn.	4-23 1929

20. Undertaker H.R.Merchant Address Clarkston Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 13 1929

White

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65943

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. 1102 - 14th. Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John H. Bethel

(a) Residence. No. 1102 - 14th. Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 3, 1859

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
70	2	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER John H. Bethel

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Sarah Noble

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Mrs. J. H. Bethel
(Address) Lewiston

15. Filed May 10, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 20, (Day) 1929. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929, to April 20, 1929
that I last saw him alive on April 19
and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus.
Diabetic Coma
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Diabetis Mellitus
(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cardiac symptoms

(Signed) E. L. White, M. D.

4-23, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Cemetery
Date of Burial: Ap. 20 1925

20. Undertaker: Brown & Warm
Address: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65944

PLACE OF DEATH

County of Nezperce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. 126 - 10 th. St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nellie B. Yardley

(a) Residence. No. 126 - 10 th. St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 12/27/1883.

7. AGE	Years	Months	Days	If LESS than 1 day,
	45	3	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Redding, Kansas

PARENTS

10. NAME OF FATHER Wm. Tillottson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana.
12. MAIDEN NAME OF MOTHER Hattie Swan.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana.

14. Informant Geo. Yardley.
(Address) Lewiston, Idaho.

15. Filed May 10, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 22nd, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1928, to April 22, 1929
that I last saw her alive on April 22, 1929
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:

Chronic endo & myo Cardi
(acute myocarditis) 1 day.
(duration) 2 yrs. mos. d

CONTRIBUTORY (Secondary) Same
(duration) yrs. mos. d

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M.
4/24/29., 19 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLEN CAUSES, state (1) MEANS AND NATURE OF INJURY, and (whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	4/24/29. 19
20. Undertaker	Address
Brower-Vann Company.	Lewiston, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65945

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 95

Primary Registration District No. 1009

Local Registrar's No.

(No. In 1200 block on F Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ira White Stalnaker.

(a) Residence. No. 605 16th, Street. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Divorced.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 5/21/1870.

7. AGE: Years 58. Months 11. Days 2. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Randolph County, West Virginia.

PARENTS

10. NAME OF FATHER: Oliver C. Stalnaker.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Randolph County, West Virginia.

12. MAIDEN NAME OF MOTHER: Susan Mustoe.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bath County, Virginia.

14. Informant: R. E. Stalnaker
(Address) Orofino, Idaho.

15. Filed May 10, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 23rd, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——, 19, to ——, 19

that I last saw h ~~alive on~~, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Unknown - probably
Heart disease type unknown
Found dead on side walk.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History of weak heart

(Signed) E. L. White, M. D.

4/25/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Southwick, Idaho. Date of Burial: 4/26/29. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65946

PLACE OF DEATH

County of Nezperce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. 0313 - Sixth St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas. Monroe Nixon

(a) Residence. No. 0313 - Sixth St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 19, 1857.

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	3	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Calvin Co. Ill.

PARENTS

10. NAME OF FATHER Louis C. Nixon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va.
12. MAIDEN NAME OF MOTHER Rebecca Grey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind.

14. Informant Mrs. Joseph Pertsling
(Address) 616 C St. Moscow, Idaho

15. Filed May 10, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April, 25, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-25, 1929, to 4-25, 1929
that I last saw him alive on 4-25 1929
and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J M Nixon M. D.
4-29 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho. Normal Hill	4/26/29 19

20. Undertaker	Address
Brower - Wann Co.	Lewiston, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65947

PLACE OF DEATH

County of Nezperce

City of Lewiston, Idaho.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. 7th. Ave. & 3rd. St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harry Lydon

(a) Residence. No. 7th. Ave. & 3rd. St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 21, 1868

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work City Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) City of Lewiston
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pierce City, Idaho.

PARENTS

10. NAME OF FATHER Micheal Lydon

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Alice Coats

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs. Lydon
(Address) Lewiston, Ida.

15. Filed May 10, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April, 25, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25, 1929, to April 25, 1929
that I last saw him alive on April 25, 1929
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:
(Chronic myocarditis)
acute Dilatation of Heart
(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) E. G. Broadock, M. D.
April 29, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho. Normal Hill	4/28/29 19

20. Undertaker	Address
Brower - Wann Co.	Lewiston, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65948

PLACE OF DEATH

County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lester James Lore

(a) Residence. No. 2812 - 2nd St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6. DATE OF BIRTH (month, day and year): Feb 16th 1928

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Lewiston Idaho

PARENTS

10. NAME OF FATHER: Gregory Lore
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Italy
12. MAIDEN NAME OF MOTHER: Maryanna Muzzio
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy

14. Informant: Gregory Lore
(Address): Lewiston Ida

15. Filed May 10, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1929, to April 26 1929, that I last saw him alive on April 26 1929, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Convulsions (duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary): not known (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Saw Convulsion

(Signed) D C Pearson M. D.
4/30, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	4 28 1929

Undertaker: Wasson — Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65950

PLACE OF DEATH

County of Nezperce
City of Lewiston, Ida.

Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Charles Ragner Hilding

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Amanda L Peterson

6. DATE OF BIRTH (month, day and year) Nov. 18, 1886

7. AGE	Years	Months	Days	If LESS than 1 day,
	52	5	10	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Chas Hilding

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Johanna Nelson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs Charles Hilding
(Address) Asotin, Wash

15. Filed May 10, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28, 1929, to April 28, 1929
that I last saw h[illegible] alive on April 28, 1929
and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Auto accident
Basil skull Fracture
2 hrs
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Same
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms.

(Signed) E L White, M. D.
4/30, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Clarkston Mem Coeur D'Alene Ida — Date of Burial 4/30 1929

20. Undertaker H.R.Merchant — Address Clarkstonwn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 1 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65951

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 95
Primary Registration District No. 1009
(No. N. Lewiston)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Junatia Hazel Galano

(a) Residence. No. N. Lewiston St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 10 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
---- --	-----	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston
(State or country) Idaho

PARENTS

10. NAME OF FATHER William Galano
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Mary Orrino
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant William Galano
(Address) Lewiston Idaho

15. Filed April 8, 19 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-27, 1929, to 3-31, 1929
that I last saw her alive on 3-30, 1929
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M. D.
3-31, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	4/1/29 19
20. Undertaker: Vassar Mortuary	Address: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-35 RECEIVED MAY 3 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 65953
Registered No. 24

1. PLACE OF DEATH
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Wright Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: March - 28 1926 (Month) (Day) (Year)

7. AGE: 3 Yrs. ..... Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Malad Ida.

10. NAME OF FATHER: Richard Morse Anderson

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Vivian C. Wright.

13. BIRTHPLACE OF MOTHER (State or Country): Lucien Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Richard Anderson
(Address) .....

15. Filed 4/30 1929 J. W. Kerns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. 25 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 1929 to April 25 1929 that I last saw h. alive on April 25 1929 and that death occurred on the date stated above, at 9 15 M.

The CAUSE OF DEATH* was as follows:
Ruptured Appendix
General Peritonitis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. B. Makey M. D.
4/25 1929 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canaria — DATE OF BURIAL: Apr 28 1929

20. UNDERTAKER: J. Guy Hansen — ADDRESS: Malad Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. RECEIVED APR 29 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65954

Local Registrar's No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Owyhee

City of Grand View

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 74

Primary Registration District No. 2151

(No. ..... St.)

2. FULL NAME Cliola Esther Foreman Wroughton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F.	white	married

6. DATE OF BIRTH

September (Month) 2nd (Day) 1894 (Year)

7. AGE

34 Yrs. 7 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho, Castle Creek

10. NAME OF Father Thomas A. Foreman

11. BIRTHPLACE OF FATHER (State or Country) St. Charles Co. Mo.

12. MAIDEN NAME OF MOTHER Fannie Ratliff

13. BIRTHPLACE OF MOTHER (State or Country) Van Zant Co. Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Delos Foreman

(Address) Castle Creek

15. Filed Apr 27 1929 W. J. Akenbeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April (Month) twenty-fifth (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10th 1929 to April 24th 1929, that I last saw h.er alive on April 24th 1929, and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. 1 mos. 15 ds.

Contributory (Secondary) Pneumonia

(Duration) yrs. ..... mos. 21 ds.

(Signed) W. J. Akenbeck M. D.

4/26 1929 (Address) Grand View

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Oreana

DATE OF BURIAL Apr. 26 1929

20. UNDERTAKER C. G. Zacher

ADDRESS Mt. Home

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR 18 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 74

Primary Registration District No. 2151

File No. 65955

Registered No. 42

1. PLACE OF DEATH

County of Owyhee

City of Bruneau

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Albert Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: 2 (Month) 14th (Day) 1854 (Year)

7. AGE: 75 Yrs. 1 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cal.

10. NAME OF FATHER: Jerad Taylor

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Elizabeth Perkins

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fletcher Taylor

(Address) Bruneau Idaho

15.

Filed Apr. 16 1929 W. J. Eikenbeck Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 7th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ did not attend deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): old age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. J. Eikenbeck M. D.

Apl. 16 1929 (Address) Grand View

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Bruneau Ida. DATE OF BURIAL: 4/10 1929

20. UNDERTAKER: G. S. Zacher ADDRESS: Mt. Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 1 16 RECEIVED APR 18 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65956

Local Registrar's No. 43

1. PLACE OF DEATH

County of Owyhee

City of Bruneau

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 74

Primary Registration District No. 2151

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dale Bretton Borne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) single

6. DATE OF BIRTH October (Month) 2nd (Day) 1925 (Year)

7. AGE 3 Yrs. 6 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father Clayton Borne

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Reva Purjue

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Reva Borne (mother)

(Address) Bruneau

15. Filed Apr. 17th 1929 W J Eikenbusch Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 15th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11th 1929 **to** April 15 1929, **that I last saw him alive on** April 15th 1929, **and that death occurred on the date stated above, at** 11:30 PM

The CAUSE OF DEATH* was as follows:

Scarlet fever

(Duration) ... yrs. ... mos. 5 ds.

Contributory (Secondary) Epilepsy

(Duration) ... yrs. ... mos. ... ds.

(Signed) Wm J Eikenbusch M. D.

Apr. 16 1929 (Address) Grand View

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bruneau

DATE OF BURIAL Apr. 16. 1929

20. UNDERTAKER C. G. Zacher

ADDRESS Mt. Home

RECEIVED MAY 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65957

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 12

2. FULL NAME Wilbur D Graham

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M
4 COLOR OR RACE: W
5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Mar 5 1849

7 AGE Years 80 Months Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS
10 NAME OF FATHER Isaac Graham
11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.
12 MAIDEN NAME OF MOTHER Nancy Eastman
13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Mrs L. E. Surber
(Address) Payette Ida

15 Filed Apr 3, 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar (Month) 31 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 1920, to Mar 30, 1929, that I last saw him alive on Mar 30, 1929, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic prostatitis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J R Woodward M. D.
Apr 1, 1929 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Payette Ida, Date of Burial: Apr 2 1929

20. Undertaker: I H Adair, Address: Peterson Furn Co Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65958

PLACE OF DEATH

County of Payette
City of Payette

CERTIFICATE OF DEATH

Registration District No. 4
Primary Registration District No. 1008
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 13

2. FULL NAME Melvin H Hopper

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb 27 1919

7 AGE: 10 Years | Months 1 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Colo

PARENTS
10 NAME OF FATHER: A. F. Hopper
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ill
12 MAIDEN NAME OF MOTHER: Pearl L Rose
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Okla.

14 Informant: A. F. Hopper
(Address): Payette Ida

15 Filed Apr 10, 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Apr. (Month) 3 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr. 3, 1929, to Apr. 3, 1929, that I last saw him alive on Apr. 3, 1929, and that death occurred, on the date stated above, at 8:30 P.m.

The CAUSE OF DEATH* was as follows:
Automobile accident

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Fractured skull.

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? None
(Signed) Merrill K. Fox M. D.
Apr 4, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Payette Ida
Date of Burial: Apr 5 1929

20. Undertaker: J. H. Adair
Address: Peterson Furn Co Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY [illegible] 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65959

PLACE OF DEATH
County of Fayette
City of Fayette
Registration District No. 4
Primary Registration District No. 1008
(No.)
Local Registrar's No. 16
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Janet Kirkendall

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of C O Kirkendall

6 DATE OF BIRTH (month, day and year) Sept 6 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10 NAME OF FATHER Baker Brawson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind
12 MAIDEN NAME OF MOTHER Mary Evans
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant C.O. Kirkendall
(Address) Payette Ida

15 Filed Apr 29 1929 J.C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr (Month) 24 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1928, to Apr 24, 1929.
that I last saw her alive on Apr 24, 1929
and that death occurred, on the date stated above, at 10 30 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma - nasopharynx

approx. (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? None
(Signed) Merrill R. Toft, M. D.
Apr 26, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Payette Ida	Apr 27 1929
20. Undertaker D.N. Cadan	Address
Peterson Furn Co	Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 3 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65960

PLACE OF DEATH

County of Power

City of American Falls, Idaho

Registration District No. 25

Primary Registration District No. 2072

Local Registrar's No. 7

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William W. Wall

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Wall

6. DATE OF BIRTH (month, day and year): April 22nd 1844

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84	11	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: W.W.Wall Sr

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Englamd

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: W.W. Wall Jr.
(Address) American Falls, Idaho

15. Filed Apl. 15, 1929 Genevieve Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11 th (Day) 1929 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Was found dead in the field
Cause, Cerebral Hemorrhage
Had been dead about 48 hrs
when found. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) A W Davis Coroner, M. D.

4/15/ 29, 19.... (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: American Falls, Ida

Date of Burial: 4/16/29 19

20. Undertaker: A W Davis

Address: American Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 3 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65961

PLACE OF DEATH

County of Power
City of Amer Fall

Registration District No. 25
Primary Registration District No. 2072
(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Kyle Leslie Johnson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
0

6 DATE OF BIRTH (month, day and year)

7 AGE Years | Months | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Country Idaho

PARENTS
10 NAME OF FATHER Bennie Johnson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Montana
12 MAIDEN NAME OF MOTHER Irene Nelson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho

14 Informant Mrs Leslie Nelson
(Address) Amer Falls

15 Filed 4-23, 1929 Genevieve Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 31 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mch 29, 1929, to Mch 31, 1929, that I last saw him alive on Mch 29, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) V G Figar, M. D.
4-2, 1929 (Address) Amer Fall Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: American Falls
Date of Burial 19

20. Undertaker
Address

RECEIVED MAY 3 1

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 29

DO NOT WRITE IN THIS SPACE
State File No. 65962

PLACE OF DEATH

County of Power
City of American Falls
Idaho

Registration District No. 29
Primary Registration District No. 2072
(No.)
Local Registrar's No. 9

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Orval Harrington,

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Not Known

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 82			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) N.Y.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Aw Davis
(Address) Am Falls Ida.

15 Filed 4-23, 1929 Gruenin Nolt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January (Month) 13th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,
that I last saw h alive on , 19 ,
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Frozen To Death Jan 13. 1929
on the deasert south west of
American Falls,
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Aw Davis Coroner
April 19, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F Cemetery	April 20 1929

20. Undertaker	Address
Aw Davis	Am Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 3 1929

CERTIFICATE OF DEATH

65963

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Power

City of Crystal

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 25

Primary Registration District No. 2072

(No. ..... St.)

File No. 10

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Lowell Whiting

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Jan. (Month) 6. (Day) 1929 (Year)

7. AGE: ..... Yrs. 1 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Pocatello, Bannock, Idaho

10. NAME OF FATHER Ralph A. Whiting

11. BIRTHPLACE OF FATHER (State or Country) Utah, Utah

12. MAIDEN NAME OF MOTHER Katheryne Irene Snyder

13. BIRTHPLACE OF MOTHER (State or Country) Idaho, Bannock

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margary Hayden Postmaster

(Address) Crystal Idaho

15. Filed 4-23 1929 Genevieve Nott Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 8. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Suppose Pneumonia

Did not have Dr. or undertaker

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Genevieve Nott Local Registrar

4/23 1929 (Address) American Falls. Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Crystal, Idaho	Feb. 10, 1929
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Ralph L. Whiting

now lying buried in Crystal Cemetery, in the City or Town of Crystal(Arbon Valley)

County of Power State of Idaho, who died on the 8th day of February, 1929, Aged ____years ____months

____days, the cause of death being Pneumonia and not directly or indirectly by diphtheria;(membranous croup);scarlet fever;smallpox;leprosy;asiatic cholera;typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

None attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private
private or railway conveyance

to Restlawn Cemetery in the City or Town of Pocatello County of Bannock

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Power it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 23rd day of May, A.D. 1977.

Permit issued to:
Manning Funeral Chapel
510 North Twelfth Ave.
Pocatello, Idaho 83201

Janet M. Wick
by _____ Director, Division of ~~Vital Statistics~~

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City,

Town or County of _____ State of Idaho, this _____ day of _____, 19___.

_____
Health Officer

FORM BH 56-019

RECEIVED MAY 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65964

PLACE OF DEATH

County of Power

City of American Falls, Idaho

Registration District No. 23

Primary Registration District No. 2072

Local Registrar's No. 41

(No. Bethony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Homer A. Pease

(a) Residence. No. Rockland, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 16th 1854

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	75	2	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Albert Pease

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant David Pease
(Address) Rockland, Idaho

15. Filed 4-29-1929 Genevieve Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 21, 1929, to Apr 28, 1929 that I last saw him alive on Apr 27, 1929 and that death occurred, on the date stated above, at 3:15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Operation for acute appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Apr 21, 29

Was there an autopsy? Yes

What test confirmed diagnosis? Physical signs

(Signed) E. F. Schenck, M. D.

April 29th 1929 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rockland Ida	April 30 1929

20. Undertaker A W Davis Address American Falls, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 6 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

65964

C.F. Schiltz
American Falls, Ida.

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

E. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:
Homer A. Pease who died at American Falls, Idaho on April 28, 1929

Cause of death given as "Cerebral Hemorrhage" "Acute Nephritis"

Information DESIRED in order to complete certificate.

Please state the cause for the relief of which the operation was performed.

MAY WE HAVE THIS IMMEDIATELY AS WE ARE HOLDING UP GOVERNMENT COORESPONDENCE WAITING FOR YOUR REPLY.

PLEASE ANSWER BELOW

acute appendicitis

RECEIVED MAY 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65965

PLACE OF DEATH

County of Power

City of American Falls, Ida

Registration District No. 25

Primary Registration District No. 2072

Local Registrar's No. 12

(No. Bethony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mattie Lloyd

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: E.V.Lloyd

6. DATE OF BIRTH (month, day and year) Dec 22 1887

7. AGE: Years 42 Months 4 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Ind

PARENTS

10. NAME OF FATHER: William Perkins

11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....

12. MAIDEN NAME OF MOTHER: Verginia Miller

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant: E V Lloyd

(Address) American Falls, Idaho

15. Filed 5-1, 1929 Genevieve Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 28th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 20, 1929, to April 28, 1929

That I last saw her alive on April 28, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Parenchymatous Nephritis (Chronic)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) V G Logan, M. D.

April 29th 1929 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: I.O.O.F. am falls

Date of Burial: May 1s 1929

20. Undertaker: Arodavis

Address: American Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65966

Local Registrar's No. 18

PLACE OF DEATH
County of Power
City of American Falls,
Registration District No. 21
Primary Registration District No. 2072
(No. Bethony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jasper Oliver Cotent

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Cotent

6. DATE OF BIRTH (month, day and year) April 7th 1849

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Charles Cotent
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.
12. MAIDEN NAME OF MOTHER Rebecca Taylor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Chas T Cotent
(Address) American Falls, Idaho

15. Filed 5-1, 1929 Genevieve Nolt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 29th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1929, to April 29, 1929
that I last saw h[illegible] alive on April 29, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Hemiplegia
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W G Logan, M. D.
April 29, 1929 (Address) American Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F. am. Falls	May 2nd 1929

20. Undertaker A. W. Davis
Address American Falls, Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65967

PLACE OF DEATH

County of Shoshone

City of Kellogg

Registration District No. 123

Primary Registration District No. 2201

Local Registrar's No. 18

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marie Lemich

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mike Lemich

6. DATE OF BIRTH (month, day and year) Sept 21 1876

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	6	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10. NAME OF FATHER Daniel Jelinek

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Austria

12. MAIDEN NAME OF MOTHER Mary .....

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Austria

14. Informant Michael Lemich Jr.

(Address) Kellogg Idaho

15. Filed Apr. 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1929, to 4/3/, 1929
that I last saw h.. alive on 4/2/, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? X-ray - Sputum

(Signed) G. S. MacDonald M. D.
4/15/, 1929 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Idaho	April 5, 1929
20. Undertaker	**Address**
M. C. Thornhill	Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65968

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 220 (
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 19

2. FULL NAME Arthur Camolli.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 25, 1928

7. AGE	Years	Months	Days	If LESS than 1 day,
		4	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kellogg Ida
(State or country)

PARENTS

10. NAME OF FATHER Joe Camolli
11. BIRTHPLACE OF FATHER (city or town) Italy
(State or Country)
12. MAIDEN NAME OF MOTHER Jessie Caldarida
13. BIRTHPLACE OF MOTHER (city or town) Italy
(State or Country)

14. Informant Joe Camolli
(Address) Kellogg, Idaho

15. Filed Apr. 30, 1929 Mrs. Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH mason

16. DATE OF DEATH Apr 6, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 5, 1929, to Apr 6, 1929
that I last saw him alive on Apr 5, 12 AM, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Inflammation of Bowels

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. R. Mason, M. D.
4/15, 1929 (Address) Kellogg, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg, Ida	Apr 7, 1929
20. Undertaker	Address
M. C. Thornhill	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65969

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 3201
Local Registrar's No. 20
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joe Vasso

(a) Residence, No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 10-1887

7. AGE	Years	Months	Days	If LESS than 1 day,
	42	7	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Alsac Lorraine

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Osana Hand
(Address) Evonville

15. Filed Apr. 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1922, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Branchial cyst Probably Tuberculas.
Did not see deceased during last illness (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. C. Lindsay, M. D.
4/20, 1929. (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Ida	Apr. 21 1929
20. Undertaker	Address
P. L. Stark	Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65970

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 21

2. FULL NAME Harrison Taylor

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 24 - 1909

7. AGE Years 20 Months Feb 1 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Constitution Mfg. Co

9. BIRTHPLACE (city or town) (State or country) Kettle Falls Wash

PARENTS

10. NAME OF FATHER John Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.C.
12. MAIDEN NAME OF MOTHER Celia Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) W. Va.

14. Informant Mrs Ava Gunn
(Address) Kellogg Ida

15. Filed Apr. 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13, 1929, to April 20, 1929
that I last saw him alive on April 20, 1929
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Constitution Mine Pine Creek
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? ~~per~~ assultation
(Signed) Geo H Kennett, M. D.
April 21, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Meyers Falls Wash — Date of Burial Apr. 22 1929

20. Undertaker R. L. Stout — Address Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65971

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2207
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 52

2. FULL NAME Floyd Daniel Ross

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 15-1926

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
2	11	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg Ida

PARENTS

10. NAME OF FATHER Floyd Ross.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bison Kansas
12. MAIDEN NAME OF MOTHER Margaret Hughes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales.

14. Informant Floyd Ross
(Address) Kellogg Ida

15. Filed Apr. 30, 1929. Mrs. Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr. (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8th, 1929, to April 23, 1929
that I last saw him alive on Apr 23rd, 1929,
and that death occurred, on the date stated above, at 1030 P. m.
The CAUSE OF DEATH* was as follows:
Anterior Polyo Myelitis.

..... (duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Unknown.
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Symptomatology.
(Signed) W. L. Lindsay, M. D.
Apr 25, 1929 (Address) Kellogg Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg Ida
Date of Burial: April 26 1929

20. Undertaker: R. L. Stant
Address: Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 65972

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 10111

(No. Providence Hospital)

Local Registrar's No. 20

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME John Anderson

(a) Residence. No. Mullan Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Karin Anderson

6 DATE OF BIRTH (month, day and year) Dec 18-1857

7 AGE: Years 70 | Months 2 | Days 13 | If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Andrew Gudeson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Andrew John Anderson

(Address) Mullan

15 Filed Mar 7, 1929 J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 1 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928, to May 1, 1929 that I last saw b[illegible] alive on Mar 28, 1929 and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Tumor of Spinal Cord Perhaps Cor-Culonia

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Dr. Mowery M. D.

2/1, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Mullan, Idaho. Date of Burial: March 7 1929

20. Undertaker: J. A. Bever Ward Undertaking Co. Address: Wallace, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 23 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65973

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Shoshone — Registration District No. 7o

City of Wallace — Primary Registration District No. 1011

(No. Providence Hospital)

Local Registrar's No. 21

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME William Deatley.

(a) Residence. No. Mullan, Idaho. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced — HUSBAND of (or) ~~WIFE~~ of: Edna May Deatley

6 DATE OF BIRTH (month, day and year): Dec 7 ½

7 AGE — Years: 52 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mine Foreman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Morning Mine

9 BIRTHPLACE (city or town) (State or country): Marysville Ky

PARENTS

10 NAME OF FATHER: Henry Thomas Deatley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mrs Lloyd Jessen
(Address): Mullan Idaho

15 Filed Mar 8, 1927 — [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Mar 5 (Month) (Day) 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 25 1927, to Mar 5 1927, that I last saw him alive on Mar 4 1927, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH was as follows: Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Lupus Erythematodes

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Howell, M. D.

3/6, 1927 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Mullan Ida — Date of Burial: 3/8 1927

20. Undertaker: Bruce G. Nordell — Address: Wallace Ida.

RECEIVED APR 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65974

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Shoshone Registration District No. 70

City of Wallace Primary Registration District No. 1011

(No. Providence Hospital)

Local Registrar's No. 22

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ivan Floyd

(a) Residence. No. Coeur d Alene Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1909 - 8 - 23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
19	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer - Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Black Rock, Ark.

PARENTS

10 NAME OF FATHER Wm. Floyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Missouri

12 MAIDEN NAME OF MOTHER Jessie Neece

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Black Rock, Mo.

14 Informant Jessie Thompson,

(Address) Coeur d'Alene, Idaho.

15 Filed Mar 8, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar (Month) 7 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to March 7, 1929, that I last saw him alive on March 7, 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute hepatitis

(duration) 9 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. K. Dunlap, M. D.

3/8/29, 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Couer d Alene Ida By Hearse — Date of Burial: 19

20. Undertaker: Worstell Co — Address: Wallace

J S Shaughnessy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65976

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1011 (No. Providence Hosp.)
Local Registrar's No. 24
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Robert Joseph Dickeson

(a) Residence. No. Burke, Idaho St. Burke Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 29 - 1928

7 AGE: Years | Months: 4 | Days: 21 | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS
10 NAME OF FATHER Clyde J. Dickeson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Iowa
12 MAIDEN NAME OF MOTHER Mable Oliver
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia City, Idaho.

14 Informant Clyde J. Dickeson
(Address) Burke, Idaho.

15 Filed Mar 22, 1929 J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 20 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1929, to Mar 20, 1929, that I last saw him alive on Mar 20, 1929, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:
Pneumonia Bron
Chest
(duration) ____ yrs. ____ mos. 2 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) ____ yrs. ____ mos. 3 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____

(Signed) [illegible] M. D.
3/21, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho.	March 22 1929
20. Undertaker: J. A. Bever Ward Undertaking Co.	Address: Wallace Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65977

Local Registrar's No. 25

PLACE OF DEATH

County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1917
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Evelyn Mary Yenzick

(a) Residence. No. Mullan, Idaho St. Mullan, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 5 - 1928

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	8	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS

10 NAME OF FATHER Jack Yenzick
11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.
12 MAIDEN NAME OF MOTHER Dorothy Baldwin
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wallace, Idaho.

14 Informant Jack Yenzick
(Address) Mullan, Idaho.

15 Filed Mar 24, 1929 S. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 21 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1929, to March 21, 1929, that I last saw her alive on March 21, 1929, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Erysipelas

(duration) ____ yrs. ____ mos. 11 ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) T. C. Merritt, M. D.
March 25 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Wallace, Idaho. Date of Burial: March 24 1929
20. Undertaker: J. A. Beer Ward Undertaking Co. Address: Wallace Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65978

PLACE OF DEATH

County of Shoshone
City of Wallace

CERTIFICATE OF DEATH

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 26

2. FULL NAME Musan Ovcina

(a) Residence. No. Mullan Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mae
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year): 1891

7 AGE: Years 38 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): Midnight Lease
(c) Name of employer: Mullan Idaho

9 BIRTHPLACE (city or town) (State or country): Jugo Slavia

PARENTS
10 NAME OF FATHER: Aydo Ovcina
11 BIRTHPLACE OF FATHER (city or town) (State or country): Jugo Slavia
12 MAIDEN NAME OF MOTHER: Marhha Heko
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Jugo Slavia

14 Informant: Sabit Ovcina
(Address) Spokane Wash.

15 Filed Mar 29, 1929 L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Mar 26 1929 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 23, 1929, to Mar 26, 1929, that I last saw him alive on Mar 26, 1929, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH was as follows: Encephalitis Lethargica
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Influenza
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No Bromo Punctuary
What test confirmed diagnosis?
(Signed) Drs Morwell, M. D.
Mar 27, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Butte Montana
Date of Burial: 3/29/29

20. Undertaker: Worstell Co J P Shaughnessy
Address: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 65979

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Shoshone
City of Gem

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 27

2. FULL NAME Charles Clarence Ross

(a) Residence. No. Gem, Idaho St. Gem, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Grace Ross

6 DATE OF BIRTH (month, day and year) Feb 25 - 1880

7 AGE Years 49 Months 1 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) Hecla Mine
(c) Name of employer Burke - Idaho

9 BIRTHPLACE (city or town) (State or country) Joplin Mo.

PARENTS
10 NAME OF FATHER Wm Ross
11 BIRTHPLACE OF FATHER (city or town) (State or country) Wisc.
12 MAIDEN NAME OF MOTHER Frances —
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mo.

14 Informant O. M. Ogilvie
(Address) Gem, Idaho

15 Filed Apr 2, 1929 J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 30 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1928, to March 30, 1929, that I last saw him alive on March 30, 1929, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:
Chronic bilateral pulmonary tuberculosis
(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Examination
(Signed) R. Wiercinski, M. D.
March 30, 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Wallace Idaho
Date of Burial Apr 2 - 1929

20. Undertaker J. A. Bever Ward Undertaking Co.
Address Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65980
Local Registrar's No. 28

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME John Thiard

(a) Residence. No. Delta Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) April 1 1853

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
75	11	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Placer Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lion France

PARENTS
10 NAME OF FATHER Not Known
11 BIRTHPLACE OF FATHER (city or town) (State or country) France
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Mrs Kane
(Address) Wallace Idaho

15 Filed Apr 5, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 30 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1929, to Mch 30, 1929, that I last saw him alive on March 30, 1929, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows: Myocarditis chr

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. several mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) D. A. Morgan, M. D.
4/3, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F. Cemetery Wallace	4/5/1929
20. Undertaker Worstell Co J P Shaughnessy	Address Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65981

PLACE OF DEATH
County of Teton
City of Victor

Registration District No. 77
Primary Registration District No. 2176
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

2. FULL NAME Burke Dustin

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 7th 1927

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Victor R.D. Idaho

PARENTS

10. NAME OF FATHER M Dustin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Garden City Utah
12. MAIDEN NAME OF MOTHER Effie Kunz
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rexburg Idaho

14. Informant M. Dustin
(Address) Victor, Idaho

15. Filed 4-10-1929 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25, 1929, to Apr 3, 1929, that I last saw him alive on Mar 30, 1929, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pleuritic effusion

(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) G.T. Parkinson, M. D.
4-3, 1929 (Address) Driggs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Teedron Ida.	4-5-1929
20. Undertaker	Address

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — RECEIVED MAY 19 1929

Registration District No. 77

Primary Registration District No. 2176

File No. 65982

County of Teton

City of Driggs (Ida)

(No. ..... St.)

Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith L. Murdock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 31 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lorin Murdock

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Edith Barker

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lorin Murdock

(Address) Driggs, Ida.

15. Filed 4-10-1929 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/31 1929, to 4/5 1929 that I last saw her alive on 4/5 1929 and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Don't know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. T. Palmer M. D.

4/5 1929 (Address) Driggs, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Victor Idaho — DATE OF BURIAL: 4-7-1929

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65984

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. S E Twin Falls)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Baby Hill
(a) Residence. No. 4 m S 1 E 1 S 1/4 E St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Apr 25 / 29
7. AGE Years — Months — Days 10 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Fred A Hill
11. BIRTHPLACE OF FATHER (city or town) (State or Country) S D
12. MAIDEN NAME OF MOTHER Linda Clemans
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) S D

14. Informant Fred A Hill
(Address) Twin Falls

15. Filed May 10, 1929 H N Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5 (Month) (Day) 10-15 Cleveland (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/25, 1929, to 5/5, 1929
that I last saw her alive on 5/4, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. D. Weaver, M. D.
5/8, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: May 6 1929
20. Undertaker: T C Drake
Address: Twin Falls

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 11 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Twin Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ....., ... St.)

File No. 65985

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Oscar Anderson Rmt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: — (Write the word.)

6. DATE OF BIRTH: Apr. (Month) 25 (Day) 1929 (Year)

7. AGE: ~~13~~ Yrs. — Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: S. O. Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Ester Melenna

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. O. Anderson

(Address) Twin Falls

15. Filed May 10 1929 H N Lee Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1929 (Year) 9:30

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ ..... 19 on 5/7/ 1929, that I last saw her alive on 5/7 1929, and that death occurred on the date stated above, at ~~[illegible]~~ 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Intussusception

(Duration) 20 hours Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Weaver M. D.

..... 19 ..... (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: May 8 1929

20. UNDERTAKER: F. E. Drake

ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65987

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. Alexander

2. FULL NAME Albert G. Howell
(a) Residence. No. 619 - 2nd Ave N. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ola A. Howell

6. DATE OF BIRTH (month, day and year): Mar. 13 - 1862

7. AGE: Years 67, Months 1, Days 21. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Caretaker Salmon Dam
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): East Louisiana Parish Louisiana

PARENTS
10. NAME OF FATHER: J. Oscar Howell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Sarah K. Boon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: Mrs. Ola A. Howell
(Address) 619 - 2nd Ave N.

15. Filed May 10, 1929 H. N. Tells Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 st, 1925, to May 4, 1929 that I last saw him alive on April 23, 1929 and that death occurred, on the date stated above, at 12-30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Interstitial Chronic (Lime dust deposit) Gold miner
(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary): Heart Dilation Acute
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? State Colo.
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Xray & Laboratory
(Signed) Duncan L. Alexander, M. D.
5-5-29, 19 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery — Date of Burial: 5-8 1929

20. Undertaker: White Mortuary Inc. — Address: Twin Falls Idaho

FORM V. RECEIVED MAY 11 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Twin Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1885

(No. Twin Falls Gen Hosp St.)

File No. 65988

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Shotwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct 8 1874 (Month) (Day) (Year)

7. AGE: 54 Yrs. 6 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Jacob D. Shotwell

11. BIRTHPLACE OF FATHER (State or Country): N Y

12. MAIDEN NAME OF MOTHER: Arabella J Cox

13. BIRTHPLACE OF MOTHER (State or Country): N Y

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee Shotwell

(Address) Twin Falls

15. Filed 5-10 1929 H N Leete Local Registrar

MEDICAL CERTIFICATE OF DEATH

530

16. DATE OF DEATH: May 5 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3rd 1929, to May 5 1929 that I last saw him alive on May 5 1929 and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

(1) Auto accident
(2) Skull, Fracture non-depressed.
(3) Brain Concussion severe

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary): Hemorrhage Brain.

(Duration) ..... yrs. ..... mos. ✓ ds.

(Signed) Duncan R Alexander M. D.

5-6 1929 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: May 7 1929

20. UNDERTAKER: F E Drake

ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAY 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65989

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Dahlstrom

(a) Residence. No. Rep Arms Apts St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Dahlstrom

6. DATE OF BIRTH (month, day and year) March 28-1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	—	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) Janitor Rep Arms
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bingham Utah

PARENTS

10. NAME OF FATHER Henry Dahlstrom
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Agusta —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs. Amelia Dahlstrom
(Address) Rep Arms Apts

15. Filed 5-10, 1929 A. M. Reed Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6, 1929, to Apr 21, 1929
that I last saw him alive on Apr 20, 1929
and that death occurred, on the date stated above, at 4:30 P m.
The CAUSE OF DEATH* was as follows:

Myocarditis (Acute)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cancer on face,
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~
Did an operation precede death? no Date of ~
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) J. E. Langenwalter M. D.
Apr 28, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	4-24 1929
20. Undertaker	Address
White Mortuary	Twin Falls.

TION is very important. See instruction on back of certificate.

RECEIVED MAY 1 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65990

Local Registrar's No.

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No. 7
Primary Registration District No. 2 3
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Horatio Seymour Palmiter

(a) Residence. No. Filer St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 19 1850

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	1	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N Y

PARENTS

10. NAME OF FATHER Allen Palmiter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N Y
12. MAIDEN NAME OF MOTHER Elizabeth Knight
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Leo Potter
(Address) Filer Idaho

15. Filed May 10, 1929 J. M. Lewis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1928, to April 19, 1929.
that I last saw him alive on April 19, 1929,
and that death occurred, on the date stated above, at 9 p. m.
The CAUSE OF DEATH* was as follows:

Pulmonary edema.
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis.
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) H. A. Dwight, M. D.
April 20, 1929 (Address) Filer, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sheldon Iowa	Apr. 22 1929

20. Undertaker H. C. Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65991

PLACE OF DEATH
County of Twin Falls
City of 11 11
Registration District No. 37
Primary Registration District No. 1853
(No. 235 3rd No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Susan Macauley
(a) Residence. No. 235 3rd No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day, and year) Mar 6 1849
7. AGE Years 80 Months 1 Days 21 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10. NAME OF FATHER Thelix McTaggert
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Dont know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Charlie Macauley
(Address) Boise Ida
15. Filed 5-10, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 27 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from , 1920, to April 27, 1929
that I last saw her alive on April 10 th, 1929
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:
Senility
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) John W Geoghegan M. D.
5-1, 1929. (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls — Date of Burial 4-30 1929
20. Undertaker T J Fransman — Address Twin Falls

RECEIVED MAY 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65992

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No. 253 7th Ave North)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Willet Stance
(a) Residence. No. 253 7th Ave No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 24 1868

7. AGE: Years 60, Months 5, Days 2. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Produce
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): New Jersey

PARENTS
10. NAME OF FATHER: David Stance
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New Jersey
12. MAIDEN NAME OF MOTHER: Rebecca Warren
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N. J.

14. Informant: Mrs. Willet Stance
(Address) 253 7th Ave No. City.

15. Filed 5-10, 1929. H. N. Leete, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1929, to April 26, 1929
that I last saw him alive on April 26, 1929
and that death occurred, on the date stated above, at 2 p m.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis General.
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Nephritis Chronic & Cleptic
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Blood & urine examinations
(Signed) Duncan L. Alexander M. D.
4/27/29 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: April 28 1929

20. Undertaker: J. J. Grossman
Address: Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65993

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Anna May Priest

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years | Months | Days | If LESS than 1 day, 17 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10. NAME OF FATHER David Priest
11. BIRTHPLACE OF FATHER (city or town) Idaho.
(State or Country)
12. MAIDEN NAME OF MOTHER Alice Zuzy
13. BIRTHPLACE OF MOTHER (city or town) France.
(State or Country)

14. Informant David Priest
(Address) Twin Falls R.R. 2.

15. Filed 5-10, 1929 H. N. Leete
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/24, 1929, to 4/25, 1929
that I last saw her alive on 4/24, 1929
and that death occurred, on the date stated above, at 8 a.m.
The CAUSE OF DEATH* was as follows: Premature birth

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) E. D. Weaver, M. D.
4/26, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery
Date of Burial: 4-26 1929

20. Undertaker: White Mortuary
Address: Twin Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65994

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No. 745 Main East St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME. O. S. Fuller
(a) Residence. No. 745 Main East St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 23 1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	1	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ill
(State or country)

PARENTS

10. NAME OF FATHER Fuller
11. BIRTHPLACE OF FATHER (city or town) Ill
(State or Country)
12. MAIDEN NAME OF MOTHER Sarrafee
13. BIRTHPLACE OF MOTHER (city or town) Ill
(State or Country)

14. Informant Mrs O. S. Fuller
(Address) Twin Falls

15. Filed May 10, 1929 F. M. Lee Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 23 6:00 AM
(Month) (Day) (Year) 1929

17. I HEREBY CERTIFY, That I attended deceased from April 17, 1929, to April, 1929
that I last saw h— alive on April 22, 1929
and that death occurred, on the date stated above, at 6 am m.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(duration) yrs. mos. 8 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis? Symptoms only.
(Signed) A. A. Worden, M. D.
April 24, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	May 25 1929

20. Undertaker J. D. Drake
Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65995

PLACE OF DEATH

County of Twin Falls
City of Kimberly
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. County General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William R. Summers

(a) Residence. No. Kimberly St. Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 2Nd. 1860

7. AGE	Years	Months	Days	If LESS than 1 day,
69		1	19	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mich.

PARENTS

10. NAME OF FATHER David Summers,

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Carloine Aldrich

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know,

14. Informant Mrs. W.S. Slaughter,
(Address) 129--4th Ave, No, Twin Falls

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April. (Month) 21St. (Day) 19 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 —, 19 28, to Apr 21, 19 29
that I last saw him alive on April 21, 19 29
and that death occurred, on the date stated above, at 1230 PM

The CAUSE OF DEATH* was as follows:
Chronic Cardio-vascular renal disease

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? n
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Clinical and autopsy

(Signed) J.M. Davis, M. D.
4-22, 19 29 (Address) Kimberly, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Ida.	Apr. 23 1929

20. Undertaker	Address
P.J. Grossman,	Twin Falls,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65996

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles E. Knull

(a) Residence. No. Twin Falls Route #1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Whige
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan.21--1865

7. AGE 64 Years 2 Months 16 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10. NAME OF FATHER Dont know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont know
12. MAIDEN NAME OF MOTHER Dont know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont know

14. Informant Mrs. Chas. E. Knull
(Address) Twin Falls Ida. Route #1

15. Filed 5-10, 1929 H. N. Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April. (Month) 6Th. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/6, 1929, to 4/6, 1929
that I last saw him alive on 4/6 1929
and that death occurred, on the date stated above, at 3 A.M m.
The CAUSE OF DEATH* was as follows:
Influenza Infection giving - Bronchitis Endocarditis & Myocarditis causing Acute Heart failure
(duration) yrs. 7 mos. 1 hour ds.
CONTRIBUTORY (Secondary) Bronchitis, Endo & Myo Carditis (duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) Dr John R Morgan, M. D.
4/6, 1929. (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Idaho.
Date of Burial: Apr.10Th 1929

20. Undertaker P. J. Grossman
Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 11 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 1095

(No. Twin Falls, Ida. Home Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65997

Local Registrar's No.

2. FULL NAME James McMillan

(a) Residence. No. 435 - 2nd N. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a. ~~If married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Mary C. McMillan

6. DATE OF BIRTH (month, day and year) Dec 9- 1850

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78	4	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Manager irrigation projects

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10. NAME OF FATHER John McMillan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs Marian Dimmick

(Address) 415 - 3rd Ave N. T. F.

15. Filed 5-10, 1929 J. M. Reed Registrar

MEDICAL CERTIFICATE OF DEATH 201

16. DATE OF DEATH April 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7, 1929, to April 10, 1929

that I last saw him alive on April 10, 1929

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

1. Impacted fracture right hip

2. Ruptured gastric ulcer -.

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Gen. Peritonitis

.....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy.

(Signed) H. O. Wilson, M. D.

April 10, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida	.19

20. Undertaker	Address
White Mortuary Inc	Twin Falls

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

May 25, 1929.

Dr. H. W. Wilson,

Twin Falls, Idaho. Re: 65997

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

James McMillan who died April 10, 1929.
You gave as cause of death: "Impacted fracture right hip"
2. Ruptured gastric Ulcer
General Peritonitis.

Information DESIRED in order to complete certificate:

Kindly advise WHAT KIND OF AN ACCIDENT was the primary cause of death. If an automobile accident please state whether within the city limits or on the highway. PLEASE ANSWER BELOW:

Deceased was walking to Church: A gust of wind took him off his feet & he fell upon the cement pavement, striking on right hip. This was within the city limits, just in front of the Presbyterian Church, corner of 5th ave. north & 2nd st. north, south west corner.

H. W. Wilson.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH MAY 11 1929

Registration District No. 37

Primary Registration District No. 1085

File No. 65998

County of Twin Falls

City of Twin Falls (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dragona Darlene Rose

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Feb (Month) 12 (Day) 1929 (Year)

7. AGE: — Yrs. 2 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. J. Rose

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Charlotte Adella Walters

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. J. Rose
(Address) Kimberly

15. Filed May 11 1929 M. Lewis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1929 (Year) 4:30

17. I HEREBY CERTIFY, That I attended deceased from May 28 1929 to May 28 1929 that I last saw h— alive on May 28 1929 and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Davis M. D.

May 29 1929 (Address) Kimberly Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	May 30 1929

20. UNDERTAKER	ADDRESS
F. C. Drake	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 11 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37

Primary Registration District No. 1985

File No. 65999

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of Twin Falls

(No. Twin Falls Co. & Gen. Hosp.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jessamine Brunett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July 29 (Month) 1924 (Day) (Year)

7. AGE: 4 Yrs. 11 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. W. Brunett

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Clara Flowers

13. BIRTHPLACE OF MOTHER (State or Country): Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Brunett

(Address) Twin Falls Route 3

15. Filed 5-10 1929

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1929 (Year) 8 o'clock

17. I HEREBY CERTIFY, That I attended deceased from April 15 1929 to May 16 1929 that I last saw h[illegible] alive on May 15 1929 and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction - gangrene of intestine

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. W. Wilson M. D.

April 18 1929 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: May 17 1929

20. UNDERTAKER: F. E. Drake | ADDRESS: T. Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66000

PLACE OF DEATH
County of Twin Falls,
City of Twin Falls
Registration District No. 37
Primary Registration District No. 10 Y5
Local Registrar's No.
(No. County General Hospital,)
(If death occurred in a hospital or institution, give its name instead of street and number.)

4

2. FULL NAME Mrs. Etta J. Kerr
(a) Residence. No. 421, West Main St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 2Nd. 1869

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	7	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bosworth, Missouri.

PARENTS

10. NAME OF FATHER Tom Rayburn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.
12. MAIDEN NAME OF MOTHER Mary Prathor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri.

14. Informant Victor Kerr
(Address) 421 West Main

15. Filed 5-10, 1929 H. M. Lewis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 15Th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 21, 1928, to April 15th, 1929
that I last saw her alive on April 15th, 1929
and that death occurred, on the date stated above, at 130 am.
The CAUSE OF DEATH* was as follows:
Cancer of the cervix and broad ligament.
Dykes

(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Secondary anemia.
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓ ✓
Did an operation precede death? Yes Date of Jan. 11, 1929
Was there an autopsy? No.
What test confirmed diagnosis? Microscopic laboratory diagnosis.
(Signed) Duncan L. Herman, M. D.
April 15th, 1929 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Idaho.	Apr. 18 1929
20. Undertaker P.J. Grossman	Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 1—Rev. March 1919

RECEIVED MAY 11 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66001

Registered No.

Registration District No. 37

Primary Registration District No. 18

(No. 3 7, Second Ward, Twin Falls, Idaho, Street)

1. PLACE OF DEATH

County of Twin Falls

City of Twin Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W H Wygal

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH March 27 (Month) (Day) 1857 (Year)

7. AGE 72 Yrs. 11 Mos. ds. 14

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER W H Wygal

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Mary E Durrett

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary B Wygal

(Address) Berger Idaho

15.

Filed May 12 1929 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

4.30

16. DATE OF DEATH May 11 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1929, to April 11 1929, that I last saw h— alive on April 11 1929, and that death occurred on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction (acute)

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H W Wilson M. D.

April 1929 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sunset Cemetery	May 13 1929

20. UNDERTAKER	ADDRESS
J E Drake	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAY 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66002

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
(No. ...)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. ...

2. FULL NAME Elizabeth Schild

(a) Residence. No. 1½ SW Falls St. Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Oct 28 1879

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
49	5	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10. NAME OF FATHER David Wermeister
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Mary Wermeister
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant Henry Schild
(Address) Twin Falls R#1

15. Filed 5-10, 1929 H. M. Lee Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 14 1929 2 o'clock
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-14-, 1929, to 4-14-, 1929
that I last saw h[er] alive on 4-14-, 1929
and that death occurred, on the date stated above, at 2:00 P m.
The CAUSE OF DEATH* was as follows:

Haemorrhage of the Brain
(duration) yrs. mos. 8 hrs.
CONTRIBUTORY (Secondary) High Blood Pressure
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinically
(Signed) H M Lee M. D.
4-15, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	May 17 1929

20. Undertaker F C Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66003

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 87

Primary Registration District No. 1095

Local Registrar's No.

(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wayne William Miller

(a) Residence. No. Filer, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 6, 1918

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
10	6	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Twin Falls, Idaho

PARENTS

10. NAME OF FATHER Walter W. Miller

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Louie James

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Walter Miller,

(Address) Filer, Idaho. Route #2.

15. Filed 5-10, 1929 H. McKenta Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29, 1929, to April 12, 1929
that I last saw him alive on April 12, 1929
and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:
Osteomyelitis,

(duration) yrs. mos. 16 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of March 29-March 30, April 2;

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Physician, M. D.

April 13, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	4/14/29

20. Undertaker Hyde Mortuary, Inc. Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66004

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Albert Dean Mallowoth

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 26th 1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buhl.

PARENTS

10. NAME OF FATHER P. M. Mallowoth

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Kate Webb

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant P. W. Mallowoth
(Address) Buhl Ida

15. Filed 4-17, 1929. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 26, 1929, to Apr 7, 1929
that I last saw h— alive on Apr 7, 1929
and that death occurred, on the date stated above, at 5 50 p m.
The CAUSE OF DEATH* was as follows:
Bronchio pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) E. L. Burny M. D.
Apr 8, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl.	4/8 1929
20. Undertaker L. Johnson	Address Buhl. Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66006

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marie Lola Huston

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Dan Huston

6. DATE OF BIRTH (month, day and year) Nov. 4. 1908

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20.	4	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buhl Ida.

PARENTS

10. NAME OF FATHER C. H. Hardesty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Ollie M. Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant C. H. Hardesty
(Address) Buhl Ida.

15. Filed 5-11, 1929 J. T. Mumford Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 26 (Day) 29 (Year) 1929

17. I HEREBY CERTIFY, That I attended deceased from 12-3, 1928, to 4-26, 1929
that I last saw her alive on 4-26, 1929
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Embolism
two hrs.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Organic Heart Disease
about 3
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) Geo. Jennings M. D.
4-27, 1929 (Address) Buhl, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl Ida	4-27 1929
20. Undertaker L. D. Johnson	Address Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66007

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 25

2. FULL NAME Catharine M Aiken

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Thomas Aiken

6. DATE OF BIRTH (month, day and year) June 18-1847

7. AGE 81 Years | Months 9 | Days 29 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Beloit Wisconsin

PARENTS
10. NAME OF FATHER Phillip Burroughs
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Abigal P. Pattee
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. H.

14. Informant Martha A Anderson
(Address) Weiser Ida

15. Filed Apl 18, 1929 M. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Ap. (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1929, to Ap 17, 1929
that I last saw her alive on Ap 17, 1929
and that death occurred, on the date stated above, at 5.30 m.
The CAUSE OF DEATH* was as follows:
Senility
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Carcinoma of bowel
..... (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) W H Marshall, M. D.
Ap 18, 1929 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Chicago Ill | Date of Burial 19

20. Undertaker L. C. Northam | Address Weiser Ida

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66008

Local Registrar's No. 24

Registration District No. .....
Primary Registration District No. .....

PLACE OF DEATH
County of Washington
City of Weiser
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Washington Barnett

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	Widower

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Rose Barnett

6. DATE OF BIRTH (month, day and year) Aug 15 - 1856

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72	7	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) ..... (State or country) Miss

PARENTS

10. NAME OF FATHER Wm Barnett
11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) So Carolina
12. MAIDEN NAME OF MOTHER Lethia Johnston
13. BIRTHPLACE OF MOTHER (city or town) ..... (State or Country) So Carolina

14. Informant Edwin D. Barnett
(Address) Weiser. Idaho

15. Filed 4/9, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ap. 5, 1929, to ap. 5, 1929, that I last saw him alive on ap 5, 1929, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Senility.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dat.

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) W. W. Marshall, M. D.
ap 9, 1929 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	4-8-1929
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66009

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. Marshead)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

2. FULL NAME John M. Whitman
(a) Residence. No. Weiser St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE Years 43 Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rail Road work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) New York

PARENTS
10. NAME OF FATHER Joseph Whitman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mary Albright
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Louis Whitman
(Address) Martinsburg, Neb.
15. Filed April 9, 1929. M. K. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 4 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 19[illegible] to Ap 4, 1929
that I last saw him alive on Ap. 4, 1929
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hemorrhage
(duration) yrs. mos. 1 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? X Ray.
(Signed) W. W. Marshall, M. D.
Ap 9, 1929 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial 4-8-1929
20. Undertaker L. C. Northam — Address Weiser Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66010

Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. 22

PLACE OF DEATH
County of Washington
City of Weiser

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Johathan Moulton

(a) Residence. No. Emmett Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Colr	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Lorena Moulton

6. DATE OF BIRTH (month, day and year) July 8 - 1848

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	8	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER W. H. B. Moulton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Martin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant John Moulton
(Address) Weiser Ida

15. Filed March 27, 1929 W. K. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26
(Month) (Day) 1929

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1929, to March 26, 1929
that I last saw him alive on March 25, 1929
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH was as follows:
Apoplexy.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Emmett Ida.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) W. K. Hamilton, M. D.
March 27, 1929 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett. Ida	3-28 1929
20. Undertaker L. C. Morton	Address Weiser Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 266011

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME John Clagget Keithley
(a) Residence. No. Midvale, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE whr
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Florence Keithley

6. DATE OF BIRTH (month, day and year) Sept 8-1894

7. AGE Years 34 Months 6 Days 16 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Midvale Idaho

PARENTS
10. NAME OF FATHER John D Keithley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Sarah S Evans
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant W. D. Keithley
(Address) Riverside, Calif.

15. Filed 3/26, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 13, 1929, to Mar 24, 1929
that I last saw him alive on Mar 24, 1929
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. A. Marshall, M. D.
Mar 26, 1929 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Midvale Idaho — Date of Burial 3-25-1929

20. Undertaker L. C. Northam — Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

66012

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20.

PLACE OF DEATH

County of Washington

~~City~~ of Weiser

Registration District No. Mancreek

Primary Registration District No. 3

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Tote

(a) Residence. No. Thousand Springs Valley St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE Wht

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 25 1846

7. AGE Years 83 Months Days 26 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unionville Mo.

PARENTS

10. NAME OF FATHER Jim Tote

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va.

12. MAIDEN NAME OF MOTHER Mary Grover

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind.

14. Informant Herbert Alderson

(Address) Weiser Idaho

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 23 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 22, 1929, to Mar. 23, 1929

that I last saw her alive on Mar 22, 1929

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart

Sinality Rheumatism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F A Schmid, M. D.

3-23-, 1929 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mancreek

Date of Burial 3, 24, 1929

20. Undertaker L. C. Northam

Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66013

Registration District No. .....

Primary Registration District No. .....

Local Registrar's No. 19

PLACE OF DEATH

County of Washington

City of Weiser

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Norman S. Alderson

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W. Hr	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 10 - 1929

7. AGE Years	Months	Days	If LESS than 1 day,
	1	9	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Baker Oregon
(State or country)

PARENTS

10. NAME OF FATHER Lloyd Alderson

11. BIRTHPLACE OF FATHER (city or town) Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Doris Hemsucker

13. BIRTHPLACE OF MOTHER (city or town) Oregon
(State or Country)

14. Informant Lloyd Alderson

(Address) Weiser Idaho

15. Filed 3-20, 1929 W. R. Krumm
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows

Sick only few hours probably acute indigestion died upon physicians arrival

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) L. C. Northam Coroner M.D.

3-20, 1929 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mann's Creek	3-20 1929

20. Undertaker	Address
L. C. Northam	Weiser Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 86

DO NOT WRITE IN THIS SPACE
State File No. 66014

RECEIVED MAY 7 1929

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No.
Primary Registration District No. 1010
Local Registrar's No. 18

(No. 7)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Samuel Rolston

(a) Residence. No. 336 E Com St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Wht
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Elizabeth Rolston

6. DATE OF BIRTH (month, day and year) June 9-1866

7. AGE: Years 63 | Months 9 | Days 4 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Vermont

PARENTS
10. NAME OF FATHER: Samuel S. Rolston
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Bowman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant: Earl W. Rolston
(Address) Weiser Idaho

15. Filed 3-14, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928, to Feb 10, 1929
that I last saw h— alive on Feb 10. 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:

Carcinoma of bowel
(duration) 1 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. O. Marshall, M. D.
Mar 17, 1929 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	3-15-1929
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66015

Local Registrar's No. 17

PLACE OF DEATH

County of Washington
City of Weiser
Registration District No. 56
Primary Registration District No. 2112
(No. R.D. No 2.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David Alvin Hoover

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	Sing'l

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 20 - 1925

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	9	13	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Alvin Hoover

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Pearl Johnson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Texas.

14. Informant Alvin Hoover
(Address) Weiser, Idaho

15. Filed March 4th, 1929. W. R. Richardson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
2-12-, 1929 to 3-27, 1929
that I last saw him alive on Feb. 27th, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Simple meningitis
following pneumonia
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) E. C. Hiatt, M.D.
....., 19..... (Address) Weiser, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	3-5 1929
20. Undertaker L. C. Northam	Address Weiser, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1929

PLACE OF DEATH

County of Washington

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66016

Local Registrar's No. 16

2. FULL NAME John Edwin Lolley

(a) Residence. No. Mains Creek St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Rose Lolley

6. DATE OF BIRTH (month, day and year) May 26-1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	8	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER John W Lolley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Mary R Norton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant A N Lolley

(Address) Weiser, Idaho

15. Filed Feb 20, 1929 E. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17, 1929, to Feb 20, 1929, that I last saw him alive on Feb 19, 1929 and that death occurred, on the date stated above, at 3:50 a.m.

The CAUSE OF DEATH* was as follows: Chronic Diffuse Interstitial Nephritis Myocarditis Cystitis and Hypertrophied Prostatitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Ernest Freeney, M.

2/20, 1929 (Address) Weiser, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mains Creek	2-23 1929
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66017

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No.
Primary Registration District No.
(No. Morehead hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15

2. FULL NAME Mrs. Lena Beatrice Stephens
(a) Residence. No. 35 West Park St. Weiser, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 11 yrs. 3 mos. ~~1~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Henry Stephens

6. DATE OF BIRTH (month, day and year) June 12, 1887

7. AGE Years 42 Months 7 Days ~~23~~ 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer S. J. Fisher

9. BIRTHPLACE (city or town) Fulton
(State or country) Missouri

PARENTS
10. NAME OF FATHER S. J. Gilbert
11. BIRTHPLACE OF FATHER (city or town) Carter County
(State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Nancy Ann Ruth Clay
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Canada

14. Informant Helene B. Keown
(Address) 710 L St Sacramento Calif

15. Filed Feb 25, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12, 1929, to Feb 19, 1929
that I last saw her alive on Feb 19, 1929
and that death occurred, on the date stated above, at 4:10 a.m.
The CAUSE OF DEATH* was as follows: Cirrhosis Hepatic Lentic with Chlorosis.
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypostatic Pneumonia
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phys. Exam.
(Signed) Ernest O. Finney, M. D.
2/20, 1929 (Address) Weiser Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hillcrest Cemetery — Date of Burial: 2-24 1929

20. Undertaker: L. C. Northam — Address: Weiser Ida

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66018

PLACE OF DEATH:
County of Washington
City of Weiser

Registration District No. ____
Primary Registration District No. 10-10
(No. ____)
Local Registrar's No. 14

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary G. Wheeland

(a) Residence. No. 700 E Court St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of C. B. Wheeland

6. DATE OF BIRTH (month, day and year) Dec 2 - 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	2	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Terre Haute Indiana

PARENTS
10. NAME OF FATHER Von Ketter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) dont know
12. MAIDEN NAME OF MOTHER King
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Ramon Wheeland
(Address) Huntington Oregon

15. Filed Feb 14th, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5, 1928, to Feb. 10, 1929
that I last saw her alive on Feb. 10, 1929
and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows:
Myocarditis (Chronic)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) F. A. Schmidt, M. D.
2-14, 1929 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Weiser, Idaho	2-15 1929
20. Undertaker L. C. Northam	Address Weiser Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66019

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1110
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 18

2. FULL NAME Alvin Judd
(a) Residence. No. Court East St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: single

6. DATE OF BIRTH (month, day and year): Jan 24th 1929

7. AGE: Years | Months | Days: 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Weiser Idaho

PARENTS
10. NAME OF FATHER: ?
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ~~Idaho~~ ?
12. MAIDEN NAME OF MOTHER: Georgana Judd
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Viviana Larson
(Address) Weiser Idaho

15. Filed March 1, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1929, to Jan 31, 1929
that I last saw him alive on Jan 28, 1929
and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows:
Premature birth
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) F. A. Schmidt, M. D.
1-31-, 1929 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

MAY 16 1929

106020

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66020

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No.
(No. Co Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME Cephus D. Welch
(a) Residence. No. Twin Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 5 - 1856

7. AGE Years 72 ~~73~~ Months 10 Days 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Hickory Township
(State or country) Mercer Co. Penn.

PARENTS

10. NAME OF FATHER John Welch
11. BIRTHPLACE OF FATHER (city or town) Hickory Township Mercer Co Penn
(State or Country)
12. MAIDEN NAME OF MOTHER Eliza Jane Satterfield
13. BIRTHPLACE OF MOTHER (city or town) Hickory Township Mercer Co Penn
(State or Country)

14. Informant Selina Welch
(Address) West Middlesex Penna

15. Filed 6-10, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY that I attended deceased from March 9th, 1929, to Sept 28, 1929
that I last saw him alive on Sept 28, 1929
and that death occurred, on the date stated above, at 6-15 P m.
The CAUSE OF DEATH* was as follows:
Acute Dilation of heart
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Trauma from being struck by auto on March 9th 1929 (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John W. Coughlin M.D.
4-30, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: West Middlesex Pa. Date of Burial: May 4 1929

20. Undertaker: P. J. Grossman Twin Falls Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 22 1929

66022 V

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66022

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 28

Primary Registration District No. 7004

Local Registrar's No. 126

(No. U.S. Veterans' Bureau Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Omey Dyer

(a) Residence. No. R. #5 St. Blackfoot, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. Omey Dyer

6. DATE OF BIRTH (month, day and year) Mar. 12, 1890

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	1	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colo

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant D.W.Herron

(Address) U.S.Veterans' Bureau, Boise, Idaho

15. Filed 5/1/, 1929 Paul W. McDonsey
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 1, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1929, 19..., to May 1, 1929, 19...
that I last saw him alive on May 1, 1929, 19...
and that death occurred, on the date stated above, at 7:05 A. m.

The CAUSE OF DEATH* was as follows:

Toxic Goitre and Dilatation heart, acute

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of 4-29-29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F.B. Brown, M. D.
Regional Medical Officer
U.S.Veterans Bureau, Boise, Idaho

May 1, 1929

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Blackfoot, Idaho	
20. Undertaker	Address
W.McBratney	Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

66023

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66023

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 139
(No. St Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ocea Lucile Vondekamp
(a) Residence. No. 6 & Garden ave, ~~St.~~ 111 R
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Clemants Vondecamp

6. DATE OF BIRTH (month, day and year) Nov 24 - 1901

7. AGE Years 28 Months 5 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wash Iowa

PARENTS
10. NAME OF FATHER John J. Grim
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Obtainable
12. MAIDEN NAME OF MOTHER Mary Kirkpatrick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Obtainable

14. Informant Clements A. Vondekamp
(Address) Route 2 Boise Ida

15. Filed 5/20, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/15, 1929, to 5/17, 1929
that I last saw her alive on 5/17, 1929
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Perforated ulcers of bowels
(duration) 2 yrs. ✓ mos. ds.
CONTRIBUTORY (Secondary) Pregnancy, miscarriage, & Bus appendix
(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of 5/1 '29
Was there an autopsy? Yes
What test confirmed diagnosis? autopsy
(Signed) A. J. Coats, M. D.
5/18, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Trinidad, Col. Date of Burial 1929

20. Undertaker Schreiber & McCann Address Boise, Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

66024

Form V. S. No. 5 20M.1-16-15 [illegible] 29

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66024

Registered No.

1. PLACE OF DEATH.

Registration District No. 18

Primary Registration District No.

County of Jerome

City of Jerome (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Romona Hernandez

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: August (Month) dont Know (Day) 8 81 (Year)

7. AGE: 48 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: dont Know

11. BIRTHPLACE OF FATHER (State or Country): dont Know.

12. MAIDEN NAME OF MOTHER: Dolores Rodriga

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Refugio Hernandez
(Address) Jerome Idaho

15.
Filed 5/24 1929 Chas F Zeller Local Registrar
J.M.C.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 23 (Day) 31 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1929, to May 23 1929, that I last saw h er alive on May 22 1929, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Tuberculas Pneumonia

(Duration) yrs. mos. ds.

Contributory
(Secondary) Number of
(Duration) yrs. mos. ds.

(Signed) Chas. F. Zeller M. D.
5/24 1929 (Address) Jerome, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome, Ida

DATE OF BURIAL: 5/24 1929

20. UNDERTAKER: None

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED JUN 7 1929

66025

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66025

PLACE OF DEATH
County of Teton
City of Driggs

Registration District No. 77
Primary Registration District No. 2176
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

2. FULL NAME Oswald L.W. Jorgenson

181

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ethel Jorgenson

6. DATE OF BIRTH (month, day and year) Feb. 22. 1890

7. AGE	Years	Months	Days	If LESS than 1 day,
39	39	2	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Teton Coal Co

9. BIRTHPLACE (city or town) Denmark
(State or country)

PARENTS

10. NAME OF FATHER Carl Jorgenson
11. BIRTHPLACE OF FATHER (city or town) Denmark
(State or Country)
12. MAIDEN NAME OF MOTHER Yetta Jeppesen
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Denmark

14. Informant Mrs. Ethel Jorgenson
(Address) Driggs, Idaho

15. Filed 5-8, 1929 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 5 (Day) 1929 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
carbon monoxide gas,

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) John Cowan Corner M. D.
5-7-1929 (Address) DRIGGS. IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Driggs, Idaho	5-10-1929

20. Undertaker Lewis Kiser Address Victor Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 · 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 166026

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5567
(No. 905 N. Main)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabetta Penny

(a) Residence. No. 905 N. Main St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 26-1853

7. AGE — Years: 75 | Months: 7 | Days: 26 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Ireland

PARENTS
10. NAME OF FATHER: Malachay Cafey
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Thompson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Bella Kenny
(Address) 905 N. Main

15. Filed May 24, 1929 — J. H. Lamey, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 22 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1929, to May 22, 1929
that I last saw h[illegible] alive on May 21, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Myocarditis: Chronic nephritis

(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary): Chronic nephritis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A. M. Hunton M. D.
May 24, 1929 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: May 25 1929
20. Undertaker: Schumacher & Beasley — Address: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 66027

Local Registrar's No. .....

2. FULL NAME Teresa Mayes County Hospital

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Nov. 14 21884

7. AGE: 44 Years, 6 Months, 28 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): Dr Coughlin Office,

(c) Name of employer: Dr, Coughlin

9. BIRTHPLACE (city or town) (State or country): England,

PARENTS

10. NAME OF FATHER: Wm, S Mayes

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth McCole

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mary Anderson
(Address): SanDiago Cal,

15. Filed June 3, 1929 H N Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21st, 1929, to June 2nd, 1929 that I last saw her alive on June 2nd, 1929 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows: Peritonitis from rupture of jejunum

..... (duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary): Cancer of omentum

..... (duration) ..... yrs. 8 mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of May 22-29

Was there an autopsy? Yes

What test confirmed diagnosis? ✓

(Signed) John L Coughlin, M. D.

6-3, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: San Diago Cal

Date of Burial: J E 3 1929

20. Undertaker: F, F, Drake

Address: Twin Falls

RECEIVED JUN 7

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66028

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No. 27

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank M. Sneed

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 3 1862

7. AGE — Years: 66 — Months: 9 — Days: 23 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B H & L Co

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER Frank Sneed
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Sarah S. Siberling
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant D E Eustes
(Address) 305½ Main St Wenatchee

15. Filed May 30, 1929 Mrs. Helen M. Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to May 26, 1929
that I last saw him alive on May 26, 1929
and that death occurred, on the date stated above, at 8:15 P m.
The CAUSE OF DEATH* was as follows:

Uremia (duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Urine
(Signed) Geo. H. Kennett, M. D.
May 27, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood Cemetery	May 31 1929
20. Undertaker	Address
M. C. Hunkins	Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66030

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 1005
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 30

120

2. FULL NAME David Dickinson Haworth.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 3 - 1925

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3-	6	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho

PARENTS

10. NAME OF FATHER H E Haworth.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.
12. MAIDEN NAME OF MOTHER Caroline Dickinson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisc.

14. Informant H E Haworth
(Address) 1622 Everett Caldwell Idaho

15. Filed 4-16-, 1929. John S. Meyer - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 12, 1929, to Apr. 14, 1929
that I last saw him alive on April 14, 1929
and that death occurred, on the date stated above, at ~~2:30~~ 1:45 P.M.
The CAUSE OF DEATH* was as follows:
Acute Yellow atrophy of the Liver

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Dr. M. D. Anthony, D.C.
Apr. 15, 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	4-16-1929

20. Undertaker	Address
C. V. Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66031

PLACE OF DEATH
County of Ada
City of Boise

Registration District No.
Primary Registration District No.
Local Registrar's No. 153

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James F. Wilkinson

(a) Residence. No. 1415 Warm Springs Ave. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Melissa W. Bride Wilkinson

6. DATE OF BIRTH (month, day and year): October 17 1851

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	6	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Marysville Ohio Union Co.

PARENTS

10. NAME OF FATHER: James Monroe Wilkinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maytown Penn. Lancaster Co.
12. MAIDEN NAME OF MOTHER: Laura Rebecca Kinney
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Hanover Oneida Co.

14. Informant: Mrs. Jesse M. Jackson
(Address): Boise Idaho

15. Filed 5/31, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929, to May 27, 1929
that I last saw him alive on May 24, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(duration) 35 yrs. 7 mos. 20 ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. 2 mos. 20 ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Sputum & Xray
(Signed) J. H. Braxton, M. D.
May 31, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	5/31 1929
20. Undertaker: Schneider & McLean	Address: Boise

Dr Braxton

TION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66032

PLACE OF DEATH

County of Ada
City of Boise
Registration District No.
Primary Registration District No.
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 151

2. FULL NAME Jacob Garrecht

(a) Residence. No. Idaho City St. Idaho City
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 54 yrs. 3 mos. ds. How long in U. S., if of foreign birth? 54 yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Offenbach, Germany
(State or country)

PARENTS

10. NAME OF FATHER David Garrecht
11. BIRTHPLACE OF FATHER (city or town) Offenbach
(State or Country) Germany
12. MAIDEN NAME OF MOTHER Katrina Stuttenraug
13. BIRTHPLACE OF MOTHER (city or town) Offenbach
(State or Country) Germany

14. Informant Mary Haney
(Address) Boise - Idaho

15. Filed 5/31, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 28th 1929
(Month) May (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22nd, 1929, to May 28th, 1929
that I last saw h[illegible] alive on May 28th, 1929
and that death occurred, on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Rocky Mt Pick fever
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Booth M. D.
May 31st, 1929 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	5/31 1929
20. Undertaker	Address
Schreiber & McCall	Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66033

PLACE OF DEATH
County of Ada
City of Boise
Registration District No.
Primary Registration District No.
(No. St Lukes Hospital)
Local Registrar's No. 150
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edith E. Forbes

(a) Residence. No. 2106 Harrison Blvd St.
(Usual place of abode)
Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Wilbur D. Forbes

6. DATE OF BIRTH (month, day and year) May-11-1883

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	0	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS
10. NAME OF FATHER Edwin P. Bowler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Caroline Hedges
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant W. H. Forbes
(Address) 2106 Harrison Blvd Boise Ida.

15. Filed 5/29/29 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1928, to May 26, 1929
that I last saw her alive on May 26, 1929
and that death occurred, on the date stated above, at 7 20 a.m.
The CAUSE OF DEATH* was as follows:
Auricular fibrillation
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Endocarditis
(duration) 8 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Electrocardiogram
(Signed) Ernest E. Lamb M. D.
5-28-, 1929 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	May 28 1929
20. Undertaker	Address
Summers & Kuta	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66034

PLACE OF DEATH

County of Ada
City of Boise

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 149

95

2. FULL NAME Benito Chertudi
(a) Residence. No. 821 East State St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Augustina Chertudi

6. DATE OF BIRTH (month, day and year) October 5th 1873

7. AGE Years 55 Months 7 Days 20 If LESS than 1 day, hrs, or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Track man
(b) General nature of industry, business, or establishment in which employed (or employer) at Barber Mill
(c) Name of employer Boise Paytte Lumber Co

9. BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10. NAME OF FATHER Juan Chertudi
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spain
12. MAIDEN NAME OF MOTHER Juana Bertiolacua
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spain

14. Informant John Chertudi
(Address) 821 E. State St. Boise

15. Filed 5/29, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Geo Callister M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. Johns Cemetery — Date of Burial 5/27 1929

20. Undertaker Schreiber & McCann — Address Boise Ia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66035

Registration District No.
Primary Registration District No.
Local Registrar's No. 148

PLACE OF DEATH

County of Ada.
City of Boise.
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

206 R

2. FULL NAME Donald Lawrence Thompson

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) May 25th 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	0	1

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER F. L. Thompson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boise, Idaho.
12. MAIDEN NAME OF MOTHER Ina E. Rose.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant F. L. Thompson.
(Address) Boise, Idaho. R. #5.

15. Filed 5/27, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 25th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at time of birth to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Still born.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Breech, unable to deliver
Dead.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) A. V. Bonck, M. D.
5/25/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	5/26/29

20. Undertaker Wm. McBratney. Address Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66036

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital) 117
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 147

2. FULL NAME Charles W. Tuttle

(a) Residence. No. ..... St. Star, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Blanche Tuttle

6. DATE OF BIRTH (month, day and year): Dec. 1, 1859

7. AGE: Years 69 | Months 7 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: W. F. Tuttle
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Charlotte Wilkerd
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant
(Address) R. R. 3 Nuttle - Star, Ida.

15. Filed 5/25, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1929, to May 23, 1929
that I last saw him alive on May 23, 1929
and that death occurred, on the date stated above, at 7 9 m.
The CAUSE OF DEATH* was as follows:
General Peritonitis
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Ruptured Appendix
(duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 5/21/29
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Harold W. Hone, M. D.
5/24, 1929 (Address) Eastman Bldg. Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	May 26 1929
20. Undertaker	Address
Schreiber & McCaw	Boise Ida.

Home.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66037

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 146

2. FULL NAME Napina Hanley
(a) Residence. No. 309 Washington St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

95 R

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of P. F. Hanley

6. DATE OF BIRTH (month, day and year) Feb. 1st 1950

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
79	3	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): New York City N.Y.

PARENTS

10. NAME OF FATHER: Michael Buckley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Napina ~~Hanley~~ Curley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Napina Hanley
(Address) 309 Wash. St.

15. Filed 5/25, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1929, to May 24, 1929
that I last saw h..... alive on May 23, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Rt. Partial Hemiplegia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Boise Ida
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Hemiplegia
(Signed) James H. Stewart, M. D.
5/24, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. John's Cemetery — Date of Burial: 5/27 1929

20. Undertaker: Schreiber & McCann — Address: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66038

Local Registrar's No. 145

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

(No. 501 Highland street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leila Alice Pecora.

(a) Residence. No. 501 Highland street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) July 31st 1911

7. AGE Years	Months	Days	If LESS than 1 day, * hrs. or min.
17	9	22	* ----------

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work In school.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Georgetown, Idaho.

PARENTS

10. NAME OF FATHER Frank Pecora.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Naples, Italy.

12. MAIDEN NAME OF MOTHER Janett Sorenson.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Brigham, Utah.

14. Informant Mrs. U. S. Kunz.

(Address) Boise, Idaho.

15. Filed 5/25, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 23rd 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 —, 1929, to May 23 —, 1929
that I last saw her alive on May 23 —, 1929
and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Influenza in Jan. 1929

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) M. Clemency Jaffin, M. D.

5/23/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	5/26/29 19
20. Undertaker	Address
Wm. McBratney	Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66039

PLACE OF DEATH
County of Boise Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 144

R

2. FULL NAME Frances May Wooters
(a) Residence. No. Meridian Id St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 5 1926

7. AGE: Years 3 Months 6 Days 18 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Emmett Id

PARENTS
10. NAME OF FATHER Fred L. Wooters
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colorado
12. MAIDEN NAME OF MOTHER Helen M Snyder
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Fred L Wooters
(Address) Meridian

15. Filed 5/24, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 23, 1929
that I last saw her alive on May 23, 1929
and that death occurred, on the date stated above, at 1.05 P. m.
The CAUSE OF DEATH* was as follows:
Accidental Burn of two thirds of Body Surface
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Toxaemia
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Meridian Idaho
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. N. Braxton, M. D.
May 24, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Id
Date of Burial: [illegible] 26 1929

20. Undertaker: W. S. Nestor
Address: Meridian

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66040

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 143

2. FULL NAME Baby Harris
(a) Residence. No. Parma Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) —
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May 22 - 1929
7. AGE Years Months Days If LESS than 1 day, hrs. or min. Premature Still Born
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Boise Ida

PARENTS
10. NAME OF FATHER George Harris
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vale Ore
12. MAIDEN NAME OF MOTHER Lizzie Crawford
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Boise Ida

14. Informant Geo Harris
(Address) Parma Ida

15. Filed 5/23 1929 W. H. Rhode Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Still born
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) M. J. Fuendeling M.D.
5/23, 1929 (Address) Boise RP.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Parma Ida
Date of Burial: May 23 1929
20. Undertaker: Schreiber McCann
Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66041

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 142

41

2. FULL NAME Mrs. Carrie Cline.
(a) Residence. No. Kuna, Idaho. Route #I. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. I4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Charlie A. Cline.

6. DATE OF BIRTH (month, day and year): Nov. IIth I887

7. AGE: Years 4I; Months 6; Days 9; If LESS than 1 day, ---------- hrs. or ---- min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Missouri.

PARENTS

10. NAME OF FATHER: S. W. Nealy.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.
12. MAIDEN NAME OF MOTHER: Mary Redick.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ind.

14. Informant: Mrs. Jessie Hudgins.
(Address): Kuna, Idaho.

15. Filed 5/21, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 20th I929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to May 20, 1929
that I last saw her alive on May 19, 19
and that death occurred, on the date stated above, at 6:20 A.M. m.
The CAUSE OF DEATH* was as follows:
Vincent's Angina following hysterectomy
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Uterine fibroid, hemorrhage
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Fred. A. Young Ex, M. D.
5/20/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kuna Cemetery
Date of Burial: 5/22/29 19

20. Undertaker: Wm. McBratney.
Address: Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66042

PLACE OF DEATH

County of Ada.
City of Boise,
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 141
(No. 220 East Jefferson street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Sarah J. Knowles.

(a) Residence. No. 220 East Jefferson St.
(Usual place of abode)
Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mathew Knowles

6. DATE OF BIRTH (month, day and year) Oct. 9th 1844

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	6	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Geneva, Ill.

PARENTS
10. NAME OF FATHER Benjamin Boyes.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bradford, England.
12. MAIDEN NAME OF MOTHER Mary Ann Holroid.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Florence K. Fahrney.
(Address) Boise, Idaho

15. Filed 5/21, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 21st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to May 21, 1929
that I last saw her alive on, 1929
and that death occurred, on the date stated above, at 1:25 A.M.
The CAUSE OF DEATH* was as follows:

Senile Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical Symptoms

(Signed) Fred A. Schaefer, M. D.
5/21/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rosehill Cemetery. Chicago, Ill.	Shipped 5/22/29 19
20. Undertaker	Address
Wm. McBratney.	Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66043

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Teresa's Academy)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 140

2. FULL NAME Caroline Larby

(a) Residence. No. ..... St. 88a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Larby

6. DATE OF BIRTH (month, day and year) Nov. 1 - 1864

7. AGE Years 64 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Austria.

PARENTS
10. NAME OF FATHER John Krakosky
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Austria
12. MAIDEN NAME OF MOTHER Mary ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Austria

14. Informant Mary Cooper.
(Address) Gooding, Idaho

15. Filed 5-20, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17, 1929, to May 17, 1929
that I last saw her alive on May 17, 1929
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:

Valvular Heart

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Rheumatism

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas V Gennoney M. D.
....., 19.... (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. Johns Cemetery — Date of Burial 5/20 1929

20. Undertaker Schreiber & McCann — Address Boise, Ia

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66044

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 138

2. FULL NAME Jennie E Ball
(a) Residence. No. Banks Ida St. 118 K P
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Warren Ball

6. DATE OF BIRTH (month, day and year): July 9. 1892

7. AGE: Years 36 Months 10 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Clear Creek Utah

PARENTS

10. NAME OF FATHER: Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not obtainable
12. MAIDEN NAME OF MOTHER: Leafy Kempton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not obtainable

14. Informant: Warren Ball
(Address): Smith Ferry

15. Filed 5-20, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 16 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to May 16, 1929
that I last saw h..... alive on May 16, 1929
and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows:
Acute intestinal obstruction
2 day duration
Sure Peritonitis
..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Sweet Idaho
Did an operation precede death? Yes Date of May 13 1929
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) James L. Stewart, M. D.
May 8, 1929 (Address) 1 Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 5/19 1929

20. Undertaker: Schreiber & McCauns
Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66045

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 10404
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 137

118a

2. FULL NAME John Wesley Dickson
(a) Residence. No. Pinney Bldg. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 21 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary B Dickson

6. DATE OF BIRTH (month, day and year) July 25 1856.

7. AGE: 72 Years, Months 9, Days 22. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Marshalltown Iowa

PARENTS

10. NAME OF FATHER: John Dickson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Catharine Boylin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Michigan

14. Informant: Mrs Mary B Dickson
(Address) Pinney Bldg. Boise Idaho

15. Filed May 17, 1929. W. H. Rhodes, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/13, 1929, to 5/17, 1929
that I last saw him alive on 5/17, 1929
and that death occurred, on the date stated above, at 5:40 a m.
The CAUSE OF DEATH* was as follows:
Strangulated Hernia
(duration) yrs. mos. 11 ds.
CONTRIBUTORY (Secondary) Ventral Hernia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 5/14/29
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) Alfred Budge Jr., M. D.
5/17, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: May 18 1929

20. Undertaker: Summers & Krebs
Address: Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66046

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 136

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

(No. St Lukes Hospital

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Morton Venable

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: January 23 1843 (Month) (Day) (Year)

7. AGE: 86 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining Man
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF Father: Joseph M Venable

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Adelia Cockrane

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Mary R Venable
(Address) 1120 Chamberlain St Boise

15.
Filed May 16 1929 W. H. Rhodes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1929 to May 15 1929, that I last saw h.. alive on May 15 1929, and that death occurred on the date stated above, at 1:30 M.

The CAUSE OF DEATH* was as follows:

Myocarditis
Asthma

(Duration) about yrs. mos. ds.

Contributory (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) Customary M. D.

19 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....ds.
Where was disease contracted if not at place of death? Unknown
Former or usual residence Boise Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery DATE OF BURIAL: May 17 1929

20. UNDERTAKER: Summers & Tribe ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66047

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 135

2. FULL NAME Frances Helen Ford,
(a) Residence. No. 819 N. 17 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 23, 1849

7. AGE: 79 Years, Months 8, Days 21. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Penn

PARENTS
10. NAME OF FATHER: Seth Tuck
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Helen Coleman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn

14. Informant: Mrs. W. E. Sullivan
(Address) 819 N. 17 St. Boise Idaho

15. Filed May 16, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 30, 1929, to May 3, 1929
that I last saw her alive on May 3, 1929
and that death occurred, on the date stated above, at 4 A. m.
The CAUSE OF DEATH* was as follows:
Myocarditis
Arteriosclerosis
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Asthma
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. H. Koelsch M. D.
May 4, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wilkes-Barre Pa. Date of Burial: May 28 1929

20. Undertaker: Summers & Kubs Address: Boise Idaho

Lanfaugh

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66048

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 134

(No. 135½ Warm Springs Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Minnie LaFawn Boeck.

(a) Residence. No. 135½ Warm Springs Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Boeck.

6. DATE OF BIRTH (month, day and year) September 18-1889

7. AGE Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
39	7	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Florrisent, Colo.
(State or country)

PARENTS

10. NAME OF FATHER T. H. Guffey.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Ky.

12. MAIDEN NAME OF MOTHER Serina E. Roberts.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Mo.

14. Informant Dr. John Boeck.
(Address) Boise, Idaho.

15. Filed 5/16, 1929. W. W. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 14th 1929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from
8-8-27, 19, to 5-14-29 19
that I last saw her alive on 5-13-29, 19
and that death occurred, on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis to Lungs (duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of Aug. 1927
Was there an autopsy? No
What test confirmed diagnosis? Microscopic Exam.

(Signed) Ernest E. Fairbaugh M. D.
5-14-29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	5-16-29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OR DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Braptun

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66049

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 133
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Anna Elizabeth Beggs.

(a) Residence. No. 622 N. 10th street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

R

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edmund H. Beggs.

6. DATE OF BIRTH (month, day and year) February 27th 1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	2	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Richmond, Ind.

PARENTS

10. NAME OF FATHER George F. Sherman.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Dorothea Weber.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant W. B. Pratt.
(Address) Boise, Idaho.

15. Filed 5/14, 1929 W. H. Rhodes, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 14th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 14, 1929
that I last saw her alive on May 13, 1929
and that death occurred, on the date stated above, at 12:35 A.M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Acute Hepatitis
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Lab. Blood etc

(Signed) J. M. Braptun, M. D.
5/14/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	5/15/29 19
20. Undertaker Wm. McBratney.	Address Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66050

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 133

PLACE OF DEATH

County of Ada
City of Boise
(No. St. Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Vondekamp
(a) Residence No. 6th & Garden St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Wht.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of May 13 - 1929

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
—	—	—		3 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Boise Ida
(State or country)

PARENTS

10. NAME OF FATHER Clem Vondekamp
11. BIRTHPLACE OF FATHER (city or town) Germany
(State or Country)
12. MAIDEN NAME OF MOTHER Lucile Grim
13. BIRTHPLACE OF MOTHER (city or town) Iowa
(State or Country)

14. Informant C. A. Vondekamp
(Address) 6th & Garden

15. Filed 5/14, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Carcinoma of liver
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. J. Coats, M. D.
..., 19... (Address) Boise,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. John's Cemetery	May 13 1929
20. Undertaker	**Address**
Schreiber & McLean	Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66051

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 131

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carrie (Carnolie) Vanasse Clautier.

(a) Residence. No. 122 Warm Springs Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Clautier

6. DATE OF BIRTH (month, day and year) June 28-1859

7. AGE Years 69 Months 10 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Canada.

PARENTS

10. NAME OF FATHER Alexander Vanasse
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Margaret La Salle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs J M Moriarty
(Address) 3850 Seventh St. San Diego Cal.

15. Filed 5/14, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-11-29, 19..., to 5-10-, 1929
that I last saw him alive on 5-10-29, 19...
and that death occurred, on the date stated above, at 10 ~~45~~ am
The CAUSE OF DEATH* was as follows:
Chronic Endocarditis
(duration) 9 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chr. Nephritis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Montana
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Only
(Signed) Ernest E. Lanbaugh M. D.
5-11-29, 19... (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Helena, Mont. Date of Burial 5/14 1929

20. Undertaker Schreibee & McCann Address Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66052

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 130

2. FULL NAME Henry N. Dorman
(a) Residence. No. 1201 - No. 7th St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

92 R

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ida Frost Dorman

6. DATE OF BIRTH (month, day and year) Feb. 26-1862.

7. AGE: 67 Years, Months 2, Days 11. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mining
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Blue Grass Ill.

PARENTS

10. NAME OF FATHER: William Dorman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Caroline Effil
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Henry Dorman
(Address) Boise Idaho

15. Filed 5/9, 1929 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Feb~~ May 7, 1929 ~~26~~ ~~19~~ (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-26-, 1929, to May 7, 1929
that I last saw him alive on May 7, 1929
and that death occurred, on the date stated above, at 7:10 a. m.
The CAUSE OF DEATH* was as follows: Pulmonary Embolus
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Hypertrophy of Prostate, Prostatitis, Chron. (duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 4/14/29
Was there an autopsy? no
What test confirmed diagnosis? - Phys. Exam.
(Signed) Ernst E. Laubaugh M. D.
5-7-29, 19 (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: ~~M~~ Caldwell Ida. Date of Burial: May 9 1929

20. Undertaker: Summers & Krebs Address: Boise Ida.

Boeck.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66053

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 129

2. FULL NAME Mrs. Clara Showers.
(a) Residence. No. Mayfield, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Married.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Clifford Showers.
6. DATE OF BIRTH (month, day and year): February 1875
7. AGE: Years 54 | Months | Days | If LESS than 1 day, ... hrs, or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Middle Park Colorado

PARENTS
10. NAME OF FATHER: Marksbery,
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know.
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Clifford Showers.
(Address) Mayfield, Idaho.

15. Filed 5/8, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 5th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 1st, 1929, to May 5th, 1929 that I last saw her alive on May 5th, 1929 and that death occurred, on the date stated above, at 2 P.M. m.

The CAUSE OF DEATH* was as follows:
Spotted fever — Hemorrhagic type
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Tick bite
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) John Boeck M. D.
5/6/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 5/9/29 19

20. Undertaker: Wm. McBratney.
Address: Boise, Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66054

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 128
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1004 R

2. FULL NAME Mary Josephine Hanagan

(a) Residence. No. 802 Eastman St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Nov. 14 - 1927

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	5	20	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello

PARENTS

10. NAME OF FATHER Frank J. Hanagan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Ida B. Hughs

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Frank J. Hanagan
(Address) Boise Idaho

15. Filed 5/7, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1929 to May 4, 1929
that I last saw h[e] alive on May 4, 1929
and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:
acute Septic Bronchopneumonia
Intestinal Intoxication
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Bowel Intoxication
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of May 3 1929
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) W. H. Wahle, M. D.
, 19 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Johns Cemetery	5/7 1929
20. Undertaker Schreiber & McCann	Address Boise Ida

Dr. Wahle

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Irenaine

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66055

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 129
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harry Donald Purcell.

(a) Residence. No. I6 I9 N. I4th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) May 26th I929

7. AGE Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
0	II	I0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Harry L. Purcell.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Halifax, Nova Scotia.

12. MAIDEN NAME OF MOTHER Beryl Cruikshand.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Stewiaske, Nova Scotia.

14. Informant Harry L. Purcell.
(Address) Boise, Idaho.

15. Filed 5/6, 19 29 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 6th I929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929 to May 6, 1929
that I last saw him alive on May 5, 1929
and that death occurred, on the date stated above, at 7:I5 A.M.

The CAUSE OF DEATH* was as follows:
Meningitis due to a
mixed respiratory infection
(duration) — yrs. — mos. 5 ds.
CONTRIBUTORY (Secondary) Secondary anemia
(duration) — yrs. 1 mos. — ds.

18. Where was disease contracted if not at place of death? At home.
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Spinal fluid tests.
(Signed) Harmon Irenaine, M. D.
5/6/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	5/7/29 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) **Salesman**, (b) Grocery; (a) **Foreman**, (b) **Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, **as Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum**, etc., **Carcinoma, Carcoma**, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia**," "PUERPERAL **peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably such, if impossible to determine definitely.** Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66056

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 126

2. FULL NAME Isidoro Guenaga
(a) Residence No. 613 Idaho St. 111a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) 1892

7. AGE 37 Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheep herder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Joe Bennett Spain

PARENTS
10. NAME OF FATHER Domingo Guenaga
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spain
12. MAIDEN NAME OF MOTHER Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spain

14. Informant Benito Ysursa
(Address) Boise Ida

15. Filed 5/6, 1929 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/12, 1929, to 5/3, 1929
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Gastric Ulcer
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hemorrhage General Gastric
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of
Was there an autopsy? yes
What test confirmed diagnosis? Operation
(Signed) Fred A. Pittenger, M. D.
5/7, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St Johns Cemetery — Date of Burial 5/6 1929

20. Undertaker Schreiber & McCann — Address Boise Ida

Dr. Pittenger

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66057

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 32

(No. Idaho State Penitentiary.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

R

2. FULL NAME W. H. Hockings.

(a) Residence. No. Penitentiary. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 29th 1842.

7. AGE: Years 86, Months II, Days 23. If LESS than 1 day, ---------- hrs. or ---------- min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Stock Raiser.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kilrain, Iowa.

PARENTS

10. NAME OF FATHER: Don't Know.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Pearl Allen.
(Address) Boise, Idaho.

15. Filed 5/24, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 23rd 1929. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1929, to May 23, 1929 that I last saw him alive on May 23, 1929 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Idaho State Pen

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) O H Parker, M. D.

5/23/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: County Cemetery. Date of Burial: 5/24/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66058

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 47

(No. Ada County Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Scott.

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
89			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Stock Business.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ky.

PARENTS

10. NAME OF FATHER: Don't Know.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Merle See.
(Address): Boise, Idaho.

15. Filed 5/13, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 11th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1928, to May 11, 1929
that I last saw him alive on May 10, 1929
and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? Ada County

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. H. Bradshaw, M. D.

5/11/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	5/13/29 19
20. Undertaker: Wm. McBratney.	Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66059

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2004

(No. Five Mile.)

Local Registrar's No. 48

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna Eliza Payton

(a) Residence. No. Five Mile. St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

57 R 30

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles Payton.

6. DATE OF BIRTH (month, day and year) Oct. 9th 1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	7	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10. NAME OF FATHER Joe Anderson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Kate Robertson.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know.

14. Informant Mrs. Fred Roton.

(Address) Boise, Idaho.

15. Filed 5/13, 1929 W. R. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May IIth 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929, to May 11th, 1929 that I last saw her alive on May 10, 1929 and that death occurred, on the date stated above, at 2:22 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Gangrene of both legs.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John T. Bonck M. D.

5/II/29 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Poole, Nebraska.	19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66061

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 44
(No. U. S. Veterans' Hospital, Boise, Idaho 28
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David Riach
(a) Residence. No. Buhl Idaho St. Buhl Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

49 50

Original in State House

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: X X

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 34, Months 7, Days 14; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sheepherder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10. NAME OF FATHER: George Riach
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Elizabeth MacDonald
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: M Cornelius
(Address) U S Veterans Hospital Boise

15. Filed 5/8, 1929 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 18, 1929, to May 7, 1929
that I last saw him alive on May 7, 1929
and that death occurred, on the date stated above, at 9:05 m.
The CAUSE OF DEATH* was as follows:
Mediastinal Tumor, Type undetermined. Probably Malignant
note autopsy Requested to determine type of involvement but refused by brother
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. D. Brewer, M. D.
(Address) U. S. Vet Hosp. Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Buhl Ida
Date of Burial: 19

20. Undertaker: McBrutney & Co
Address: Boise Ida

J. Boeck

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66062

PLACE OF DEATH

County of Ada
City of Barber

Registration District No. 8
Primary Registration District No. 2004
(No. Barber, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 43

16 R 27

2. FULL NAME Desmond Foster.

(a) Residence. No. Barber, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) May 5th 1929.

7. AGE: Years 0, Months 0, Days 0. If LESS than 1 day, 4 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Barber, Idaho.

PARENTS

10. NAME OF FATHER Cecil Foster.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hot Springs, Ark.
12. MAIDEN NAME OF MOTHER Elsie Myers.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Jonesburough, Ark.

14. Informant Cecil Foster.
(Address) Barber, Idaho.

15. Filed May 6, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 5th, 1929, to May 5th, 1929
that I last saw him alive on May 5th, 1929
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Non closure of Foramen Ovale of heart — congenital malformation
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Boeck M. D.
5/6/29, 19 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial 5/6/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 3 1929

PLACE OF DEATH

County of Ada.

City of Star

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66063

Registration District No. 9-10

Primary Registration District No. 9-10

Local Registrar's No. 1

(No. Star, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Maggie Jane Lamper.

(a) Residence. No. Star, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

-60 a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: C. A. Lamper.

6. DATE OF BIRTH (month, day and year): April 16th 1864

7. AGE: 65 Years. Months: 1 Days: 2 If LESS than 1 day, ~~hrs. or~~ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Star, Idaho.

PARENTS

10. NAME OF FATHER: John B. Smith.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Sarah Baker.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa.

14. Informant: C. A. Lamper,
(Address) Star, Idaho.

15. Filed 5/22, 1929 Orvin Jackson Registrar
Eagle Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 18th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1929, to May 18, 1929 that I last saw her dead alive on May 18, 1929 and that death occurred, on the date stated above, at 11:55 P.M.

The CAUSE OF DEATH* was as follows: Goiter.

(duration) 5 yrs. about mos. ds.

CONTRIBUTORY (Secondary) Vacacordia

(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes at home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

, 19 (Address) Star, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Star Cemetery. Date of Burial: 5/22/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAY 24 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Adams

City of Indian Valley

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. ..... St.)

File No. 66064

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Della Feaze

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH. Sept (Month) 16 (Day) 1851 (Year)

7. AGE 77 Yrs. 7 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) House wife

9. BIRTHPLACE (State or Country) Mosouri

10. NAME OF FATHER Mr Moses Vanderpool

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs John Morgan

(Address) Cambridge Ida

15. Filed May 15 1929 W M Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2050

Apr 1 (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1929, to April 1 1929, that I last saw her alive on ..... 191..., and that death occured on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Probable heart disease

Did not see her until 20 minutes after death

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Brown M. D.

4-18 1929 (Address) Starkey, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian Valley

DATE OF BURIAL: April 19 1929

20. UNDERTAKER: J A Henderson

ADDRESS: Cambridge

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 24654

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66065

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2761
(No. Pocatello General Hosp.
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5553

2. FULL NAME Grant Dalhstrom

(a) Residence. No. 241 N. 11th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years: 7 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: John B. Dalhstrom
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho Falls Idaho
12. MAIDEN NAME OF MOTHER: Mary Tardell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Mary Dalhstrom
(Address) 241 N. 11th Ave

15. Filed 5/2, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/26, 1929, to 5/2, 1929, that I last saw him alive on 5/1/29, 1929, and that death occurred, on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
(Epidemic)
(duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis? —

(Signed) A. C. Thomas, M. D.
5/2, 1929 (Address) City.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountainview Cem. | Date of Burial: 5/2/29

20. Undertaker: D. L. McClain | Address: Pocatello Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66067

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5551

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arthur P. Killion

(a) Residence. No. ..... St. 880
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July 20 1881

7. AGE: Years 47 | Months 9 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Blackfoot Idaho

PARENTS

10. NAME OF FATHER: John C Killion
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo
12. MAIDEN NAME OF MOTHER: Martha Parsons
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo

14. Informant: L. E. Killion
(Address): Blackfoot

15. Filed 4/27, 1929. J. R. Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 30, 1929, to April 27, 1929
that I last saw him alive on April 27, 1929
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows: Valvular heart disease
(duration) few yrs. mos. ds.
CONTRIBUTORY (Secondary): Ruptured Compensation ascites, oedema
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? Blackfoot, Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) N. F. Howard, M. D.
4/27/29, 19 (Address) Pocatello, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Thomas Riverside Cem | Date of Burial 19

20. Undertaker: E. F. Peck | Address: Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66068

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5550

2. FULL NAME Lelsie James Eastabrook

(a) Residence. No. ..... St. ..... 60 W
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 8th 1887

7. AGE Years 41 Months 9 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Towandia Penn.

PARENTS
10. NAME OF FATHER Wilford Eastabrook
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Nettie Chaffee
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Mrs L. Wimmer
(Address) Shoshone Ida

15. Filed 4/27, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 17, 1929, to Apr 26, 1929
that I last saw him alive on Apr 26, 1929
and that death occurred, on the date stated above, at 5:30 a.m.
The CAUSE OF DEATH* was as follows:
Oedema lungs.
Pulmonary oedema
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Oper. Guilt
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Pocatello
Did an operation precede death? Yes Date of 4/23/29
Was there an autopsy? Yes
What test confirmed diagnosis? Chr. G.B.
(Signed) H C Dawson, M. D.
4/27, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rockland Idaho
Date of Burial: 4-28 1929

20. Undertaker: Schumacher & Beasley
Address: Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66069

PLACE OF DEATH
County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5549
(No. RIVER VIEW APARTMENTS)
(If death occurred in a hospital or institution, give its name instead of street and number.)

167

2. FULL NAME FLORENCE FARLEY DEKALB

(a) Residence. No. RIVER VIEW APARTMENTS St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of VERNE DEKALB

6. DATE OF BIRTH (month, day and year) JULY 7 1904

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	24	9	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work STEOGRAPHER
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) POCATELLO IDAHO

PARENTS

10. NAME OF FATHER ED. FARLEY
11. BIRTHPLACE OF FATHER (city or town) (State or Country) OGDEN UTAH
12. MAIDEN NAME OF MOTHER JANEY BAKER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) OGDEN UTAH

14. Informant Ed Farley
(Address) Pocatello

15. Filed 4/24, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH [redacted] APRIL 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Poisoning by eliminating Gas and chloroform ~~sy~~ administered (Suicidal)
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Arthur W Hall Coroner
____, 19____ (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
OGDEN UTAH	19
20. Undertaker	**Address**
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66070

PLACE OF DEATH
County of Bannock
City of POCATELLO, IDAHO

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5548

92
88 b

2. FULL NAME Anna May Goodenough
(a) Residence. No. McCammon St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Goodenough
6. DATE OF BIRTH (month, day and year) Nov 13, 1883
7. AGE Years 45 Months 5 Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) Soda Springs
(State or country) Idaho
PARENTS
10. NAME OF FATHER John Hunter
11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) "
(State or Country)
14. Informant William Goodenough
(Address) McCammon
15. Filed 4/27, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH POCATELLO, IDAHO April 26 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 4-10, 1929, to 4-26, 1929
that I last saw her alive on 4-26, 1929
and that death occurred, on the date stated above, at 11:59 m.
The CAUSE OF DEATH* was as follows:
Myocarditis
Organic heart disease
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Thrombosis of veins of both thighs & left arm
(duration) yrs. mos. 24 ds.
18. Where was disease contracted if not at place of death? Twin Hot Springs
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. W. Brothers, M. D.
4-26, 1929 (Address) POCATELLO, IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal McCammon Idaho
Date of Burial April 27 1929
20. Undertaker McHAN UNDERTAKING CO.
Address POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66071

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 124 So. Johnson St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5547

57

2. FULL NAME Ernest Ray Loux
(a) Residence. No. 124 So Johnson St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) Oct. 20, 1891
7. AGE 37 Years | Months 6 | Days 3 | If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Electrical Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —
9. BIRTHPLACE (city or town) (State or country) McMinnville Oregon
10. NAME OF FATHER C. E. M. Loux
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indianna
12. MAIDEN NAME OF MOTHER Lessie Fuller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) West Virginia

PARENTS

14. Informant C. E. M. Loux
(Address) Pocatello Idaho
15. Filed April 24 1929 J. W. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 23 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 18, 1929 to April 23, 1929
that I last saw him alive on April 23, 1929
and that death occurred, on the date stated above, at 3 00 a m.
The CAUSE OF DEATH* was as follows:
Diabetes mellitus 3 yrs
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Diabetic Coma
(duration) yrs. mos. ds. Few hours
18. Where was disease contracted if not at place of death? California
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical and Chemical
(Signed) W. F. Howard, M. D.
4/24, 1929 (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Idaho | Date of Burial: April 25 1929
20. Undertaker: McHan Undt Co | Address: Pocatello

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66072

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. 524 WEST BONNIVILLE)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5546

1913

2. FULL NAME CORDELIA STRAUS BAUGH

(a) Residence. No. 524 WEST BONNIVILLE St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	WIDOWED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of JOHN P. STRAUS BAUGH

6. DATE OF BIRTH (month, day and year) FEB - 10, 1850

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	2	12 or 13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work RETIRED
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) OHIO

PARENTS

10. NAME OF FATHER DONNER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) GERMANY
12. MAIDEN NAME OF MOTHER UNKNOWN
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UNKNOWN

14. Informant W. L. STRAUS BAUGH
(Address) POCATELLO, IDAHO.

15. Filed 4/29, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 22 or 23rd APRIL (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:
Found dead in bed
Myocarditis had been
treated some months by Dr J. R. Young
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Arthur W. Hall. Coroner
4/29, 1929 (Address) Pocatello.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
DECATUR, ILLINOIS	ON ARRIVAL 19
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66073

PLACE OF DEATH

County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5545
(No. 1035 NORTH LINCOLN)
(If death occurred in a hospital or institution, give its name instead of street and number.)

6/29

2. FULL NAME CHRISTIAN SORENSEN

(a) Residence. No. 1035 NORTH LINCOLN St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	DIVORCED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of JENETT BYINGTON

6. DATE OF BIRTH (month, day and year) JULY 16 1863

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	65	9	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work LABORER

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) DENMARK

PARENTS

10. NAME OF FATHER UNKNOWN

11. BIRTHPLACE OF FATHER (city or town) (State or Country) UNKNOWN

12. MAIDEN NAME OF MOTHER UNKNOWN

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UNKNOWN

14. Informant MRS GEORGE SEELOR
(Address) POCATELLO IDAHO

15. Filed 4/20, 1929. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH APRIL (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-19, 1929, to 4-19, 1929
that I last saw h~~e~~ alive on 4-19, 1929
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:
Cardio Renal disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Smallpox

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of —
Was there an autopsy? NO
What test confirmed diagnosis? Clinical

(Signed) J. H. Young, M. D.
4/20, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW CEM	APRIL 21 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66074

Local Registrar's No. 5544

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

(No. Gen Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Geronikas

(a) Residence. No. Tammie Hotel St. 1-29

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? Unknown yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 45	—	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10. NAME OF FATHER G. Geronikas.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Greece

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant John Pattis

(Address) Pocatello, Ida.

15. Filed 4/20, 1929 J. M. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-10, 1929, to 4-18, 1929

that I last saw him alive on 4-17, 1929

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Renal disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. M. Young M. D.

4/20, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt View. Date of Burial 4-21 1929

20. Undertaker Schumacher & Bailey Address City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED MAY 23 1929

PLACE OF DEATH

County of Minnidaka Bannock

City of POCATELLO, IDAHO

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66075

Local Registrar's No. 5543

188a

2. FULL NAME Edward T. Burns

(a) Residence. No. 340, N. Hayes St. Pocatello Ida

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6. DATE OF BIRTH (month, day and year) Dec 12 – 1887

7. AGE 41 Years 4 Months 5 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work R. R. Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer O. S. L. R. R.

9. BIRTHPLACE (city or town) (State or country) Buffalo N. Y.

PARENTS

10. NAME OF FATHER Joseph McGoldrick Burns

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Philadelphia

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Mrs. Anna Burns

(Address) POCATELLO, IDAHO

15. Filed Apr 18, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH POCATELLO, IDAHO Apr 17 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Railroad accident died in short time

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. B. Kenagy, M. D.

Apr 17, 1929 (Address) POCATELLO, IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buffalo New York

Date of Burial Apr 18 1929

20. Undertaker McHAN UNDERTAKING CO.

Address POCATELLO, IDAHO

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66076

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hosp.
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5542

2. FULL NAME Claude W. Edwards
(a) Residence. No. 522 N. Main St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 4

7. AGE Years 52 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS
10. NAME OF FATHER Emery Edwards
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown Denham
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Dora Edwards
(Address) 522 N. Main

15. Filed 4/18, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 16/29 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-9, 1929, to 4-16, 1929
that I last saw him alive on 4-16, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Cerebral hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cardio - renal disease
(duration) yrs. ? mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) [signature], M. D.
4/18, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt View Cemetery Date of Burial 4/19/29

20. Undertaker H. L. McCann Address Pocatello Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66077

PLACE OF DEATH
County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5541
(No. COUNTY INFIRMARY)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME LOGAN BROOKS

(a) Residence. No. WITH MRS AGNES FRY
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	NEGRO	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) MARCH 17 1884

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	45	0	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work WAITER O.S.L. RR.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) IOWA

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) —
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant HYDE
(Address) 347 N. 4TH

15. Filed 4/18, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH APRIL 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1929, to April 15, 1929
that I last saw him alive on April 15, 1929
and that death occurred, on the date stated above, at 6a m.
The CAUSE OF DEATH* was as follows: Cardio Renal disease

(duration) yrs. mos. ds.
CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. H. Young M. D.
4/18, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW	APRIL 18 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED MAY 23 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66078

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5540

(No. St. Anthony's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

24

2. FULL NAME Loraine Halliwell

(a) Residence. No. 855 W. Whitman St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 5 yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Sept 21, 1923

7. AGE: Years 5, Months 6, Days 26. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho

PARENTS

10. NAME OF FATHER J. P. Halliwell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Alma P. Tressler

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Colorado

14. Informant J. P. Halliwell
(Address) Pocatello, Idaho

15. Filed 4/16, 1929 J. P. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-8, 1929, to 4-15, 1929 that I last saw her alive on 4-15, 1929 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Meningococcic meningitis (duration) ___ yrs. ___ mos. 7 ds.

CONTRIBUTORY (Secondary) ___ (duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal fluid analysis

(Signed) W. W. Brothers M. D.

4-15, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Idaho — Date of Burial: 4-16 1929

20. Undertaker: H. L. McHan — Address: Pocatello, Idaho

Grover

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66079

Registration District No. 28
Primary Registration District No. 2161
(No. Tyhee Idaho)
Local Registrar's No. 5539

(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH

County of Bannock
City of Pocatello

2. FULL NAME Tolbert Akers 149

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month) (day) (year) 22/1914

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
14	9		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grayer Kentucky

PARENTS

10. NAME OF FATHER Tom Akers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Martha Frazier
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Tom Akers
(Address) Fort Hall Idaho

15. Filed 4/14, 1929 J. H. Lawrence Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 14/29
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/14/, 1929, to 4/14/29, 19....
that I last saw h... alive on 4/14/, 19 29
and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage By Hanging (Suicide)

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) C. E. Johnson M. D.
4/16/, 19 29. (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View Cemetery	April 16/29
20. Undertaker H. L. McClain	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66080

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5538

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

128

2. FULL NAME Josephine De Gans
(a) Residence. No. 504 N Pocatello St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE Darb
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) March 28, 1855

7. AGE 44 Years Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS
10. NAME OF FATHER Richard Evan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill
12. MAIDEN NAME OF MOTHER Josephine Caldwell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant David Roger De Gans
(Address) 504 N. Pocatello

15. Filed 4/16, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 14 /29 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-10, 1929, to 4-14, 1929
that I last saw her alive on 4-14, 1929
and that death occurred, on the date stated above, at 40 M m.
The CAUSE OF DEATH* was as follows:
Acute parenchymatous nephritis
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Organic heart disease
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) W. W. Brothers M. D.
4-16, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain view
Date of Burial 4/16/29

20. Undertaker H. L. McCann
Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 14 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66081

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5509

(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

71a

2. FULL NAME Harry Harley Wensel

(a) Residence. No. Blackfoot St. Blackfoot Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. — yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) [redacted] of Alice Marie Wensel

6. DATE OF BIRTH (month, day and year) Sept. 2, 1887

7. AGE Years 41 Months 6 Days 13 If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mag Cigar Store and Barber Shop

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Melbourne, Iowa

PARENTS

10. NAME OF FATHER Lewis C Wensel

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn

12. MAIDEN NAME OF MOTHER Mary Jane Buck

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vermont

14. Informant L S Wensel
(Address) State Center Iowa

15. Filed 2/22, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26, 1929, to Feby 20, 1929 that I last saw him alive on Feby 19, 1929 and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows: Pneumococcus Meningitis Gangrene of L. Foot due to embolus of Popliteal artery

(duration) ____ yrs. ____ mos. 6 ds.

CONTRIBUTORY (Secondary) Thos F. Mullen MD

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 1/26/29

Was there an autopsy?

What test confirmed diagnosis? Spinal Puncture & Lab.

(Signed) Thos F. Mullen, M. D.

Feby 21, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Blackfoot Idaho — Date of Burial: 2-22 1929

20. Undertaker: E J Peck — Address: Blackfoot Idaho

RECEIVED MAY 22 1929

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66082

PLACE OF DEATH

County of Bannock
City of Swan Lake

Registration District No. ~~24~~ 83
Primary Registration District No. ~~2119~~ 2160
Local Registrar's No. 109
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Conrad Matkin 99e

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 3-30-1929

7. AGE Years | Months | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Swan Lake Idaho

PARENTS

10. NAME OF FATHER George G. Matkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hyde Park, Utah ~~Swan Lake, Ida~~
12. MAIDEN NAME OF MOTHER Julia Allen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Afton, Wyoming

14. Informant
(Address)

15. Filed April 20, 1929 Mary C. Coffin Registrar
May 20 1929

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 18, 1929, to Apr 20, 1929
that I last saw him alive on Apr 20, 1929
and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows: Congenital Heart Disease
(duration) yrs. mos. 20 ds.
CONTRIBUTORY (Secondary) Bronchitis
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Eugene Worley, M. D.
Apr. 20, 1929 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Swan Lake Idaho | Date of Burial Apr 22 1929
20. Undertaker | Address

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66083

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. ST. ANTHONY HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5-566

16 TH

2. FULL NAME INFANT HASTY

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) MAY 15, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	0	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work NONE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) POCATELLO, IDA.

PARENTS

10. NAME OF FATHER JOHN A. HASTY
11. BIRTHPLACE OF FATHER (city or town) (State or Country) KANSAS
12. MAIDEN NAME OF MOTHER THELMA STONE
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) IDAHO.

14. Informant JOHN A. HASTY
(Address) 320 - NO 11TH AVE. POCA. IDA

15. Filed 5/16, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MAY, 16, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-15, 1929, to 5-16, 1929
that I last saw ~~him~~ alive on 5-16, 1929
and that death occurred, on the date stated above, at 4 a, m.
The CAUSE OF DEATH* was as follows:

Patent foramen ovale

..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Prematurity 8 hrs.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? NO Date of —
Was there an autopsy? NO
What test confirmed diagnosis?
(Signed) W. W. Orthern, M. D.
5-16, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW CEMETERY	19
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66084

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. ST ANTHONY HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5565

161a

2. FULL NAME INFANT DUFFIN

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) MAY. 15 1929

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	0	0	2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work NONE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) POCATELLO IDA.

PARENTS

10. NAME OF FATHER ROLAND DUFFIN
11. BIRTHPLACE OF FATHER (city or town) (State or Country) UTAH
12. MAIDEN NAME OF MOTHER LILA PHILIPS
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UTAH

14. Informant ROLAND DUFFIN
(Address) ABERDEEN, IDAHO.

15. Filed 5/15, 1929 J. M. Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MAY. 15, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to May 16, 1929.
that I last saw ~~him~~ alive on May 16, 1929
and that death occurred, on the date stated above, at 4a m.
The CAUSE OF DEATH* was as follows:

Premature 7 mo twin.
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Spontaneous rupture of membranes & water.
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. W. Brothers, M. D.
5-16, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
ABERDEEN IDA.	MAY. 16 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66085

PLACE OF DEATH

County of BANNOCK

City of LAVA HOT SPRINGS

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5564

(No. WHITE STONE HOTEL LAVA) HOT SPRINGS

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME HYRUM WILCOX

(a) Residence. No. SALT LAKE CITY, UTAH. St. 182
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE

4. COLOR OR RACE: WHITE

5. Single, Married, Widowed, or Divorced (write the word): WIDOWED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of SIRINDA JANE ALRED

6. DATE OF BIRTH (month, day and year) OCT. 15, 1849

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
80	7	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work RETIRED

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) WYOMING

PARENTS

10. NAME OF FATHER JOSEPH WILCOX

11. BIRTHPLACE OF FATHER (city or town) (State or Country) OHIO

12. MAIDEN NAME OF MOTHER MARY IVY

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) IOWA

14. Informant F. H. WILCOX
(Address) 1111 - SO. 8TH EAST S.L.C. UTAH

15. Filed 5/16, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MAY. (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Found dead in private bath at White-Stone Hotel Lava. Apoplexy (accidental drowning)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Arthur W. Hall Coronor ~~M. D.~~

....., 19..... (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: SALT LAKE CITY, UTAH

Date of Burial: ON ARRIVAL 19

20. Undertaker: ARTHUR W. HALL

Address: POCATELLO

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66086

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 354 Monroe ave)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5563

161a

2. FULL NAME Infant Jones
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 11, 29

7. AGE Years Months Days If LESS than 1 day, ... hrs. or ..... min.
Still born

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Ida

PARENTS
10. NAME OF FATHER Elbert E. Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Arkansas
12. MAIDEN NAME OF MOTHER Leota Bryant
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas

14. Informant Elbert E. Jones
(Address) Pocatello Ida

15. Filed 5/13, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/11/29, 19..., to 5/12/, 1929
that I last saw him alive on 5/12/, 1929
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
Premature Birth
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Premature Birth
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
5/13/, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Ida
Date of Burial: May 13 1929

20. Undertaker: McHan Undt Co
Address: Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

172807

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66087

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. 816 - N - 12TH AVE.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5562

101a

2. FULL NAME MARY SOPHIA GRIFFITH

(a) Residence. No. 816 - NORTH 12TH St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of JOHN A. GRIFFITH

6. DATE OF BIRTH (month, day and year) MAR. 7, 1868

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	61	2	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work RETIRED
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) MISSOURI

PARENTS

10. NAME OF FATHER WM V. HALL
11. BIRTHPLACE OF FATHER (city or town) (State or Country) PENN.
12. MAIDEN NAME OF MOTHER MARY DELLAMY
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UNKNOWN

14. Informant MRS. DORAS A. WHITE
(Address) GOSHEN, UTAH.

15. Filed 5/11, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MAY, (Month) 10, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 20, 1929, to May 10, 1929
that I last saw h.. alive on May 10, 1929
and that death occurred, on the date stated above, at 8 a m.
The CAUSE OF DEATH* was as follows: Lobar pneumonia

(duration) yrs. mos. 15 ds.
CONTRIBUTORY (Secondary) Mitral insufficiency and stenosis, acute dilatation
(duration) yrs. mos. 20 ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Williams F. Hough M. D.
May 11, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
GOSHEN, UTAH	ON ARRIVAL 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66088

PLACE OF DEATH
County of Bonneville
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5561
(No. 1240 E Center)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Virginia Lee Armstrong
(a) Residence. No. 1240 E Center St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of W S Armstrong

6. DATE OF BIRTH (month, day and year) Feb 23 1885

7. AGE	Years	Months	Days	If LESS than 1 day,
	42	2	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10. NAME OF FATHER A Blanton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant W S Armstrong
(Address) City

15. Filed 5/11, 1929. J H Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-4, 1929, to 5-10, 1929
that I last saw her alive on 5-9, 1929
and that death occurred, on the date stated above, at 6 a.m.
The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.
5/11, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	5-12-1929
20. Undertaker	Address
Johnson & Burley	City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66089

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 21
Primary Registration District No. 2161
(No. 318-So. JOHNSON)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5560

2. FULL NAME MARGARET RUTH HAMMOND

(a) Residence. No. 318-So. JOHNSON St. 80

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) MAR. 9, 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	11	2	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work AT SCHOOL
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) AMERICAN FALLS IDA.

PARENTS

10. NAME OF FATHER LEE N. HAMMOND

11. BIRTHPLACE OF FATHER (city or town) (State or Country) UTAH

12. MAIDEN NAME OF MOTHER MARGARET POWELL

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) OHIO.

14. Informant L. N. HAMMOND
(Address) 318-So. JOHNSON POCA. IDA.

15. Filed 5/11, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MAY. 10, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to May 10, 1929
that I last saw her alive on May 10, 1929
and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Organic heart disease
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of —
Was there an autopsy? NO
What test confirmed diagnosis?

(Signed) W. W. Brothers, M. D.
5-11, 1929 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
PROVIDENCE UTAH	MAY. 12 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO.

RECEIVED MAY 2 3 1929

RECEIVED MAY 2 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66090

PLACE OF DEATH
County of Bamock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Lynn Bros Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5559

57

2. FULL NAME Anna Kennedy

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE: 82 Years, 6 Months, 14 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Penn.

PARENTS
10. NAME OF FATHER: Joseph Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: B. H. Kennedy
(Address): Pocatello Idaho

15. Filed 5/11, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to May 9, 1929
that I last saw her alive on May 9, 1929
and that death occurred, on the date stated above, at 1:30 p m.
The CAUSE OF DEATH* was as follows:
Diabetes
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): age
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? physical & urinalysis
(Signed) ....., M. D.
5/10, 1929 (Address) [signature] Pocatello Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountainview Cem. Date of Burial: 5/12/29

20. Undertaker: H. L. McHan Address: Pocatello Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 23 1929

Roberts

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66091

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5558

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

45

2. FULL NAME Agnes MacMillen
(a) Residence. No. 4B5 West Landers
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 79 Years, Months 9, Days 23. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Scotland

PARENTS
10. NAME OF FATHER: Wm Simpson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Jane Yeoman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: J. A. MacMillen
(Address) Pocatello Idaho

15. Filed 5/11, 1929. J. Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9th (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-29, 1929, to 5-7, 1929
that I last saw her alive on 5-7, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Carcinoma colon.
..... (duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) —
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Findings
(Signed) [illegible], M. D.
5/10, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountainview Cem. Date of Burial: 5/12/29

20. Undertaker: H. K. McHan Address: Pocatello Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66092

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5557

(No. O.S.L. R.R. YARDS)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1222

2. FULL NAME JAMES HAMILL

(a) Residence. No. NORTH OF CITY St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE

4. COLOR OR RACE: WHITE

5. Single, Married, Widowed, or Divorced (write the word): MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) JULY 12, 1868

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60	9	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: HELPER

(b) General nature of industry, business, or establishment in which employed (or employer): ON TRUCK

(c) Name of employer: O.S.L.R.R.

9. BIRTHPLACE (city or town) (State or country): PENNSYLVANIA

PARENTS

10. NAME OF FATHER: JOHN HAMILL

11. BIRTHPLACE OF FATHER (city or town) (State or Country): PENNSYLVANIA

12. MAIDEN NAME OF MOTHER: AGNES SHORT

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): PENNSYLVANIA

14. Informant: MRS. JAMES HAMILL
(Address) NORTH OF POCATELLO CITY

15. Filed 5/13, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: MAY. (Month) 7. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:
Found dead by Freight bar being switched in Local R.R. yards Neck Broken and crushed by cause unknown to jurors (Accidental) (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur W Hall Corner M. D.

May 13, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: MOUNTAIN VIEW CEMETERY

Date of Burial: MAY 13, 1929

20. Undertaker: ARTHUR W. HALL

Address: POCATELLO.

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66093

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. 220 - RANDOLPH ST.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5556

160

2. FULL NAME LEONE DUTTON

(a) Residence. No. 220 - RANDOLPH St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) APRIL 17, 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	0	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work NONE
(b) General nature of industry, business, or establishment in which employed (or employer) INFANT
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) POCATELLO, IDA.

PARENTS

10. NAME OF FATHER CALVIN DUTTON
11. BIRTHPLACE OF FATHER (city or town) (State or Country) PENN.
12. MAIDEN NAME OF MOTHER LILY HOLCOMB
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) KANSAS

14. Informant CALVIN DUTTON
(Address) 220 - RANDOLPH ST. POCA. IDA.

15. Filed 5/9, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MAY. (Month) 7, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to MAY 7, 1929
that I last saw her alive on MAY 7, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Congenital heart trouble

(duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) F. D. Miller, M. D.
5/7, 1929 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW CEMETERY	5-8-1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 23 1929

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66094

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. County farm)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5555

2. FULL NAME Charity Catherine Starrett

129

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE: 68 Years | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: retired house
(b) General nature of industry, business, or establishment in which employed (or employer): Keeper
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Tennessee

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tennessee
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Mrs. Ed Hashine
(Address) County farm, Pocatello

15. Filed May 8, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1927, to May 8, 1929
that I last saw her alive on May 8, 1929
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:
Cardio Renal disease
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Rheumatism
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
5/8, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Idaho | Date of Burial: May 9 1929

20. Undertaker: McHan Undt Co | Address: Pocatello

RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66095

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5554
(No. 1342 N. Garfield)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Johanna Callahan 88a
(a) Residence. No. 1342 N. Garfield St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 21-1864

7. AGE: Years 65 Months 0 Days 12 If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ireland

PARENTS
10. NAME OF FATHER: John Hickey
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: John Callahan
(Address) 1342 N. Garfield

15. Filed 5/6, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to May 3, 1929
that I last saw her alive on May 3, 1929
and that death occurred, on the date stated above, at 9:00 a.m.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
(duration) — yrs. 6 mos. — ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis? physical & [illegible]
(Signed) [signature], M. D.
5/6/29 (Address) [illegible] Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View
Date of Burial: May 6 1929
20. Undertaker: Schumacher & Beasley
Address: City

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66096

PLACE OF DEATH
County of Bear Lake
City of Bloomington
Registration District No. 52
Primary Registration District No.
Local Registrar's No. 120
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rose E. Patterson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of single.

6. DATE OF BIRTH (month, day and year) Mar 10 1887

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	2	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Edward M Patterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Thompson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant J. P. Patterson
(Address) Bloomington Idaho

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17, 1929, to May 23, 1929
that I last saw her alive on May 23, 1929
and that death occurred, on the date stated above, at 9:30 P. m.
The CAUSE OF DEATH* was as follows:
Myocarditis Chronic
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Asthma,
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Findings
(Signed) O O Moore, M. D.
5/25, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bloomington Ida	5-7 1929
20. Undertaker	Address
John Hulme	Ida Bloomington

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED JUN 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 66095
Registered No. 4
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Benewah
City of Plummer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 46
Primary Registration District No. 7172
(No. ....., ... St.)

2. FULL NAME Manford E Sischo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)
6. DATE OF BIRTH: Feb (Month) 21 (Day) 1865 (Year)
7. AGE: 64 Yrs. 2 Mos. 29 ds.
IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wisconsin
10. NAME OF FATHER: Elzier Sischo
11. BIRTHPLACE OF FATHER (State or Country): not known
12. MAIDEN NAME OF MOTHER: Sarrola Baker
13. BIRTHPLACE OF MOTHER (State or Country): Not Known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jerome Bostwick
(Address) Plummer Ida
15. Filed May 20 1929 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 18 1929 to May 20 1929
that I last saw him alive on May 18 1929
and that death occurred on the date stated above, at 9 a. M.
The CAUSE OF DEATH* was as follows:
Uraemia
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Nephritis
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Dr. C B Clizer M. D.
5-20 1929 (Address) Jerome Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rockford Wn — DATE OF BURIAL: May 22 1929
20. UNDERTAKER: [signature] — ADDRESS: Plummer

FORM V. S. No. 5-12 M. 6-15-17

RECEIVED JUN 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 66098
Registered No. 3

Registration District No. 46
Primary Registration District No. 7173

1. PLACE OF DEATH
County of Benewah
City of Rock Creek
If death occurred away from usual residence, give name of place; if called for under special information.
(No. ....., ... St.)

2. FULL NAME Berton A. Gavitt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: January (Month) 20 (Day) 1869 (Year)

7. AGE: 60 Yrs. 3 Mos. 18 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario Canada

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Hunsaker
(Address) Plummer R.F.D.

15. Filed May 15 1929 B. Jaeger Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1929 to May 8 1929
that I last saw him alive on May 8 - 1929
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Aneurism of aorta.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) L Celanter M. D.
19.... (Address) Rockford Wn

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Plummer Ida. DATE OF BURIAL: May 11 1929

20. UNDERTAKER: B. Jaeger ADDRESS: Plummer

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUN 8 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Benewah

City of Dr Smet

Registration District No.

Primary Registration District No.

(No. ..... St.)

File No. 66099

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ignace Nshieszu Ignace

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) ..... 1 (Year)

7. AGE 89 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Coeur d'Alene Reserve

10. NAME OF FATHER Regis Schizui

11. BIRTHPLACE OF FATHER (State or Country) Coeur d'Alene Reserve

12. MAIDEN NAME OF MOTHER Mary Lucy Peenchi

13. BIRTHPLACE OF MOTHER (State or Country) Coeur d'Alene Reserve

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Ignace

(Address) De Smet, Idaho

15. Filed May 14 1929 John Post Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 12 1929 (Month) (Day) (Year) 11a

17. I HEREBY CERTIFY, That I attended deceased from April 19 1929, to May 12 1929, that I last saw him alive on May 12 1929, and that death occured on the date stated above, at 1:30 M.

The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Nelson M. D.

5/13 1929 (Address) Tekoa, Wn.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: De Smet, Idaho

DATE OF BURIAL: May 14 1929

20. UNDERTAKER: C. L. Schulerud

ADDRESS: Tekoa, Wash.

SYMS - YORK CO., PTRS. & BDRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC RE
BUREAU OF VITAL STATI CS

CERTIFICATE OF DEATH

DO NOT WRITE IN TH ACE
State File No. 66101

PLACE OF DEATH
County of BINGHAM
City of B LACKFOOT

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 94
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

~~121~~ 103

2. FULL NAME HATTIE B FRANKLIN
(a) Residence. No. St. WEISER-IDAHO
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE
4. COLOR OR RACE WHITE
5. Single, Married, Widowed, or Divorced (write the word) MARRIED

5a. If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of Rev. W. M. Franklin

6. DATE OF BIRTH (month, day and year)

7. AGE 43 Years | Months 2 | Days 10 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work HOUSE WIFE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER ~~Tennessee~~
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennessee
12. MAIDEN NAME OF MOTHER ---
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Grace A. Clippinger R.N. Nurse
(Address) Blackfoot, Idaho.

15. Filed May 4, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MAY 4th, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 30th 1928, 19, to May 4th 1929, 19
that I last saw her alive on May 3rd-1929, 19
and that death occurred, on the date stated above, at 1 AM m.
The CAUSE OF DEATH* was as follows:
Gangrene of Lung
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
Eight wks. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
May 4th, 1929, 19 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Weiser Idaho | Date of Burial 19

20. Undertaker Eg F Peck | Address Blackfoot

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66102

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. South Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 93

76

2. FULL NAME WILLIAM N GROW

(a) Residence. No. ..... St. IDAHO FALLS IDA
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work R.R. BRAKEMAN
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ALBANY, OREGON

PARENTS

10. NAME OF FATHER Wm N Grow-Philadelphia Pa

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Philadelphia-Pa

12. MAIDEN NAME OF MOTHER Esther Coffin,

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Richmond, Ind

14. Informant Fred Hayes Att.
(Address) Blackfoot, Ida.

15. Filed May 4, 1929 Mrs Valeria Tate Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 4th, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 29th 1929, 19..., to May 4th 1929, 19...
that I last saw him alive on May 4th, 1929, 19...
and that death occurred, on the date stated above, at 2:30P m.
The CAUSE OF DEATH* was as follows:

Paralysis of Insane

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
May 4th, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sunnyside Idaho.	May 7 1929
20. Undertaker	Address
Jack A. Wood	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66103

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. 80 Unit)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 92

2. FULL NAME Arminda Mary Jane Lacy

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Oct 28 1860

7. AGE: Years 68, Months 6, Days 4. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): St Louis Mo.

PARENTS

10. NAME OF FATHER: Fred. Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Prussia
12. MAIDEN NAME OF MOTHER: Marrion
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: J. M. Lacy
(Address)

15. Filed May 4, 1929 Mrs Charles E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3rd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1928, to May 3rd, 1929 that I last saw her alive on May 2nd, 1929 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver & Stomach
(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? physical findings
(Signed) J. O. Humphrey, M. D.
5-4 J, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rupert Idaho
Date of Burial: 19

20. Undertaker: E. T. Peck
Address: Blackfoot

current complete April 1929

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66104

PLACE OF DEATH
County of St Hall Reservation
City of State Idaho

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 91

31

2. FULL NAME Mable Punkin

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Shoshone Ind 4/4
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Punkin

6. DATE OF BIRTH (month, day and year) 1890

7. AGE Years 39 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Hall Reservation

PARENTS

10. NAME OF FATHER Tuevitse Seaman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) St Hall - Reservation

12. MAIDEN NAME OF MOTHER Tseve

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St Hall Reservation

14. Informant Tuevitse Seaman
(Address) St Hall Idaho

15. Filed June 8, 1929 Mrs Walter G Petrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jun 1, 1929, to Apr. 24, 1929
that I last saw her alive on Apr 24, 1929
and that death occurred, on the date stated above, at 11 55 P. m.
The CAUSE OF DEATH* was as follows:
Tuberculosis of the lungs
..... (duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Physical Signs
(Signed) Henry P. Whelan M. D.
....., 19..... (Address) St Hall Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St Hall Reservation — Date of Burial 4/28 1929

20. Undertaker Hello Mortuary — Address Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

current complete

April 1929.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66105

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Fort Hall Reservation
City of State Idaho.
Registration District No. 13
Primary Registration District No. 2194
Local Registrar's No. 95

(No. 46)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mattie Towvoda

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Shoshone Ind 4/4
5. Single, Married, Widowed, or Divorced (write the word): Married.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Phillip Towvoda
6. DATE OF BIRTH (month, day and year): 1874
7. AGE: Years 55 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Lemhi Reservation

PARENTS
10. NAME OF FATHER: Buckskin.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Lemhi Reservation
12. MAIDEN NAME OF MOTHER: Coo-Coo-Do-ya-
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Lemhi Reservation

14. Informant: Virginia Tyler
(Address): Ft Hall Idaho.
15. Filed June 3, 1929 Mrs Walter E Talbot Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 23 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Treated by Dr Newton 19.. to 19.. that I last saw h.. alive on Pocatello Idaho and that death occurred, on the date stated above, at 9 30 A. m.
The CAUSE OF DEATH* was as follows:
Cancer of the uterus.
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Peritonitis
(duration) yrs. mos. 3 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laparoscope.
(Signed) Henry W. Gfeller M. D.
19.. (Address) Ft Hall Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ft Hall Reservation — Date of Burial: 4/24 1929
20. Undertaker: Hall's Mortuary — Address: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

current complete April 1929

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66106

PLACE OF DEATH
County of Ft Hall Reservation
City of State Idaho.

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 89

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Jack Edens.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Shoshone Ind 4/4
5. Single, Married, Widowed, or Divorced (write the word) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lizzie Rundall

6. DATE OF BIRTH (month, day and year) 1863

7. AGE Years 66 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Soda Springs Idaho

PARENTS

10. NAME OF FATHER Arimo.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant Tom Edens.
(Address) Ft Hall - Idaho

15. Filed June 5, 1929 Mrs Walter E Fabrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Treated by Dr Newton, 19.. to ....., 19..
that I last saw h..... alive on Pocatello Idaho
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Nephritis, Chronic.

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) myocarditis.
..... (duration) ..... yrs. ..... mos. 12 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Urinary Analysis
(Signed) Henry R. Wheeler M. D.
....., 19.. (Address) Ft Hall Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ft Hall Reservation — Date of Burial 4/14 1929

20. Undertaker McHun & Co — Address Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

current complete April 1929.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66107

PLACE OF DEATH
County of St Hall Reservation
City of State Idaho.

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 88

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Etta May Timsanico. 11 b

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Shoshone Ind. 4/4
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 12-1927

7. AGE Years 1 Months 11 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Hall Reservation

PARENTS

10. NAME OF FATHER Adasco Timsanico
11. BIRTHPLACE OF FATHER (city or town) (State or Country) St Hall Reservation
12. MAIDEN NAME OF MOTHER Annie Ingatah.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St Hall Reservation

14. Informant Annie Timsanico.
(Address) Pocatello Idaho

15. Filed June 5, 1929 Mrs Walter E Patton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from no doctor, attending, 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 6 4a m.
The CAUSE OF DEATH* was as follows:
Flu.
..... (duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary) Pneumonia, Bronchial
..... (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none.
(Signed) Henry R. Wheeler M. D.
....., 19..... (Address) St Hall Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St Hall Reservation — Date of Burial 4/17 1929

20. Undertaker Shoemaker & Beasley — Address Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

current complete

April 1929.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66108

RECEIVED JUN 8 1929

PLACE OF DEATH

County Hall Incorporation

City State - Idaho.

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 87

(No. 168)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Y. Baker.

(a) Residence. No. ..... St. .....

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Shoshone Ind. 4/4	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1833

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	94			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Jack Tendoy.

(Address) Hall - Idaho R.D.

15. Filed June 3, 1929 Mc Wallace Graham Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended, deceased from Treated by Dr. J. O. Lyons Pocatello Idaho
19..., to 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows: Suicide by hanging
Resp. ondentally by Pneumonia
Chronic Health - hepatitis
(duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of April 16 1929

Was there an autopsy? No

What test confirmed diagnosis? Investigation by Coroner

(Signed) Henry H. Wheeler M. D.

19..., 19... (Address) Hall - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Presbyterian Mission Hall Incorporation	4/16 1929

20. Undertaker	Address
Brown & Eldredge	Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

current complete April 1929.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66109

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ada Registration District No. 127
City of Boise Primary Registration District No. 3194
Local Registrar's No. 86
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jose Coby.

(a) Residence. No. / St. 24
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Spanish Ind. 4/4
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Sept. 6 1928
7. AGE: Years 0 | Months 7 | Days 4 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): A Hall Reservation

PARENTS
10. NAME OF FATHER: Archie Coby.
11. BIRTHPLACE OF FATHER (city or town) (State or country): A Hall Reservation.
12. MAIDEN NAME OF MOTHER: Hattie Soyourne.
13. BIRTHPLACE OF MOTHER (city or town) (State or country): A Hall Reservation

14. Informant: Archie Coby.
(Address): A Hall Idaho.
15. Filed June 5, 1929 McWalters Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 10 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Treated by Dr. Lynn, Boise, Idaho to , 19 ; that I last saw h alive on , 19 ; and that death occurred, on the date stated above, at 7a. m.
The CAUSE OF DEATH* was as follows:
Cerebro-Spinal Meningitis
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Henry P. Lynn, M. D.
, 19 (Address) A Hall. Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: A Hall Reservation — Date of Burial: 4/13 1929
20. Undertaker: Modern Mortuary — Address: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

current complete April 1929.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66110

PLACE OF DEATH
County of St Hall Reservation
City of State Idaho

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 85

2. FULL NAME Jerry Tendoy

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

31

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Shoshone Sand 4/4
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 5 1925

7. AGE: Years 4, Months 0, Days 3. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Hall Reservation

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown.
12. MAIDEN NAME OF MOTHER: Edna Tendoy.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Fenhi Reservation

14. Informant: Edna George
(Address) St Hall Idaho

15. Filed June 5, 1929 McWalter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from no doctor attending, 19..., to ....., 19...
that I last saw h..... alive on ....., 19...
and that death occurred, on the date stated above, at 11 P.M. m.
The CAUSE OF DEATH* was as follows:
Tuberculosis of the lungs.
..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none.
(Signed) Henry R. Wheeler M. D.
....., 19... (Address) St. Hall Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Presbyterian Mission St Hall Reservation
Date of Burial: 4/11 1929

20. Undertaker: Brown & Eldredge
Address: Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

current complete April 1929.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66111

PLACE OF DEATH
County of Ft Hall Reservation
City of State Idaho
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 84
(No.) 24
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Jackson.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Shoshone Ind 4/4	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1904

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Jackson
(State or country) Idaho

PARENTS

10. NAME OF FATHER George Jackson.
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Ft Hall Reservation.
12. MAIDEN NAME OF MOTHER Topoyo
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Ft Hall Reservation.

14. Informant George Jackson
(Address) Ft Hall Idaho.

15. Filed June 5, 1929 McWaters & Future Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2, 1929, to April 4, 1929
that I last saw h~~e~~ alive on April 4, 1929
and that death occurred, on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) Henry P. Lykins M.D.
, 19 (Address) Ft Hall Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ft Hall Reservation	4/7 1929

20. Undertaker Shoemaker & Bradley Address Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

current complete. April 1929.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66112

PLACE OF DEATH

~~County of~~ Ft Hall Reservation ~~City of~~ State Idaho.

CERTIFICATE OF DEATH

Registration District No. 127
Primary Registration District No. 3194
Local Registrar's No. 53

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jack Jonaguent.

(a) Residence. No. .... St. 110
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Shoshone Ind 4/4	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec-14-1928.

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	3	14	.... hrs. or .... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft Hall. Reservation

PARENTS

10. NAME OF FATHER Frank Jonaguent.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemhi. Reservation
12. MAIDEN NAME OF MOTHER Ida Tahueens.
13. BIRTHPLACE OF MOTHER (city or town) (State or country) Ft Hall Reservation

14. Informant Frank Jonaguent.
(Address) Ft Hall. Idaho

15. Filed June 8, 1929. McCracken & Fothuis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from no doctor attending, 19.... to ...., 19....
that I last saw h.... alive on ...., 19....
and that death occurred, on the date stated above, at 2-30 .m.
The CAUSE OF DEATH* was as follows:

Flu.

.... (duration) .... yrs. .... mos. 4 ds.
CONTRIBUTORY (Secondary) Pneumonia, bronchial
.... (duration) .... yrs. .... mos. 4 ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? no Date of ....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Henry P. Gehrke M. D.
...., 19.... (Address) Ft Hall. Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ft Hall Reservation	4/4 1929
20. Undertaker	Address
Agency Carpenter	Ft Hall Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

current complete April 1929

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66113

PLACE OF DEATH
County of St Hall Reservation
City or State Idaho.

Registration District No. 121
Primary Registration District No. 2144
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 82

2. FULL NAME Lourena Jack

(a) Residence. No. ..... St. 11a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Shoshone Ind 4/4
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 13 1928

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	0	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Hall Reservation

PARENTS

10. NAME OF FATHER Jimmie Jack.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cross Creek, Utah
12. MAIDEN NAME OF MOTHER Agnes Witcheday
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Washakie, Utah.

14. Informant Jimmie Jack
(Address) Pauline, Idaho

15. Filed June 3, 1929 Mrs Clarence Eratine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No doctor attending 19..
that I last saw h..... alive on ....., 19..
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Flu.
..... (duration) ..... yrs. ..... mos. 6 ds.
CONTRIBUTORY (Secondary) Pleumonia, bronchial
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Henry R. Wheeler M. D.
....., 19.. (Address) St Hall Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Hall Reservation
Date of Burial: 4/4 1929

20. Undertaker: Shoemaker & Beasley
Address: Pocatello Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

current complete March 1929

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66114

PLACE OF DEATH
County of St. Hall Reservation
City of State Idaho.

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 50

2. FULL NAME Benjamin Ballard

(a) Residence. No. ..... St. ..... 100 a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Shoshone Ind. 4/4
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 18, 1927

7. AGE: Years 1 Months 5 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Hall Reservation

PARENTS

10. NAME OF FATHER Julius Ballard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) St. Hall Reservation
12. MAIDEN NAME OF MOTHER Nittie Hill
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wind River Wyoming

14. Informant Julius Ballard
(Address) St. Hall - Idaho

15. Filed June 3, 1929 Mrs Walter E. Stone Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21, 1929, to March 28, 1929
that I last saw him alive on March 28, 1929
and that death occurred, on the date stated above, at 1 1 m.
The CAUSE OF DEATH* was as follows:
Pneumonia, bronchial
..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Physical signs
(Signed) Henry P. Polohuski M.D.
....., 19.... (Address) St. Hall Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Hall Reservation — Date of Burial: 3/30 1929

20. Undertaker: Shoemaker & Bensley — Address: Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

current March 1929

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66115

PLACE OF DEATH
County of St Hall Reservation
City of State Idaho

Registration District No. 12
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 50

2. FULL NAME George Cawson

(a) Residence. No. ..... St. 11a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: Shoshone Ind 4/4
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1849

7. AGE: Years 80 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lemhi Reservation

PARENTS

10. NAME OF FATHER In-ga-pag-wite.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemhi Reservation
12. MAIDEN NAME OF MOTHER Poingerah.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lemhi Reservation

14. Informant Albert Cawson
(Address) St Hall Idaho

15. Filed June 5, 1929 Mrs Clara Tatine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No doctor attending, 19..., to ..., 19...
that I last saw h..... alive on ..., 19...
and that death occurred, on the date stated above, at 7 a m.
The CAUSE OF DEATH* was as follows:
Flu.
..... (duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary) Pneumonia, Bronchial
..... (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Henry R. Wheeler M. D.
....., 19... (Address) St Hall Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Hall Reservation | Date of Burial: 3/23 1929

20. Undertaker: Agency Carpenter | Address: St Hall Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66117

PLACE OF DEATH

County of Bingham

City of Blackfoot.

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 106

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dana Orson Walton

(a) Residence. No. East Bridge, Blackfoot. Ida. St. 44
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Harriett Walton

6. DATE OF BIRTH (month, day and year): Aug. 13. 1852

7. AGE: Years 76, Months 9, Days 13. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: Dana Walton

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Rebecca Card.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio.

14. Informant: Silas Walton
(Address): Blackfoot. Ida.

15. Filed May 28, 1929 Mrs Walter E. Patrie, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May. 26. 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28, 1929, to May 26, 1929, that I last saw him alive on April 28, 1928, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of the Stomach

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary): Nephritis, Interstitial

(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. E. Patrie, M. D.

May 28, 1929 (Address) Blackfoot. Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lyman Idaho. Date of Burial: May. 29, 29 19

20. Undertaker: Modern Mortuary Address: Blackfoot, Ida

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66118

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 6007
Local Registrar's No. 105

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101b

2. FULL NAME Gertrude Maxine Paxton

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 24 1914

7. AGE Years 15 Months 3 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work in school
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot Idaho

PARENTS

10. NAME OF FATHER E. J. Paxton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden Utah
12. MAIDEN NAME OF MOTHER Sarah Goodson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lehigh Utah

14. Informant Mrs H. R. Young
(Address) Bancroft Idaho

15. Filed May 24 1929 Mrs Wilma E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to May 22, 1929 that I last saw her alive on May 22, 1929 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia
(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza
(duration) — yrs. — mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) W W Beck, M. D.
5/23, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Groom City Cemetery
Date of Burial 19

20. Undertaker: E J Peck
Address: Blackfoot

2 4a

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66119

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 104

(No. Near West Center Street Yonnie Add.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Joseph Carriveau

(a) Residence. No. 170 Blackfoot Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mildred Carriveau

6. DATE OF BIRTH (month, day and year): Dec. 15-1900

7. AGE: Years 28 | Months 5 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10. NAME OF FATHER: Joseph Carriveau

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Thressia Frity

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant: Fred Ostlund
(Address) Blackfoot Ida

15. Filed May 23, 1929 McCraker E. Paterson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 21 29 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Gunshot Wound

Suicide

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Coroners Jury

(Signed) Ray McClellan, M. D.

May 23, 1929 (Address) Coroner Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery | Date of Burial: 5-23- 1929

20. Undertaker: Modern Mortuary | Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66120

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 103

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Anthony

(a) Residence. No. ..... St. 1610
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) May 18 29

7. AGE Years | Months | Days | If LESS than 1 day, 42 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kimball Ida

PARENTS
10. NAME OF FATHER Joseph H. Anthony
11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Portage Wisc
12. MAIDEN NAME OF MOTHER William Nielsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Blackfoot Ida

14. Informant Joseph H. Anthony
(Address) Firth Idaho R.F.D. #1

15. Filed May 18, 1929 Mrs Walter E. Valvie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1929 to May 18, 1929
that I last saw him alive on Dead, May 18, 1929
and that death occurred, on the date stated above, at 3:20 p.m.
The CAUSE OF DEATH* was as follows:
Premature birth
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) None known
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. C. Roberts M. D.
May 18, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Basalt Cemetery
Date of Burial: May 18 1929

20. Undertaker
Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66121

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT
Registration District No. 127
Primary Registration District No. 2194
Local Registrar's No. 102
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME JOHN WILBUR JOHNSON

(a) Residence. No. ____ St. GRANDVIEW IDA
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 41 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	61			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS

10. NAME OF FATHER ---
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ---
12. MAIDEN NAME OF MOTHER ---
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ---

14. Informant Grace A. Clippinger Nurse
(Address) Blackfoot Idaho

15. Filed May. 16, 1929 W. McCaleb [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 18th, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 8th, 1929 to May 18th 29
that I last saw him alive on May 18th, 1929
and that death occurred, on the date stated above, at 2:45 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo Williams, M. D.
May 18th, 1929 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Mountain Home	
20. Undertaker	Address
E. J. Peck	Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66122

PLACE OF DEATH
County of Bingham
City of Shelley Ida R.D. #2

Registration District No. 121
Primary Registration District No. 2194.
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 101

2. FULL NAME Hannah Wiklund

(a) Residence. No. Shelley Ida R.D. #2 St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

88 b

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Andrew L. Wiklund

6. DATE OF BIRTH (month, day and year) July 21, 1865

7. AGE: Years 63, Months 9, Days 28. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Sweeden

PARENTS

10. NAME OF FATHER: Andrew Gust Anderson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Anna Lowgren Erxson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweeden

14. Informant: Elmer J. Wiklund.
(Address) Shelley Ida. R#2.

15. Filed May 18, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to May 18, 1929 that I last saw her alive on Apr 10, 1929 and that death occurred, on the date stated above, at 8:40 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary): Myocarditis + nephritis
(duration) yrs. mos. ds. unknown duration

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? General examination

(Signed) W W Beck, M. D.

May 18, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Firth Idaho
Date of Burial: 19

20. Undertaker: E J Peck
Address: Blackfoot

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66123

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 100
(No. 880)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Ann McMurdie

(a) Residence. No. Blackfoot. Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert K. McMurdie

6. DATE OF BIRTH (month, day and year) Mar. 25, 1868

7. AGE

Years	Months	Days	If LESS than 1 day,
61	1	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: William Miles
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Margaret Ann Hocky
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England.

14. Informant R. K. McMurdie
(Address) Blackfoot Rt.

15. Filed May 6, 1929 M. Stoaler E. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May. 17. 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1928, to May 17, 1929
that I last saw her alive on May 15, 1929
and that death occurred, on the date stated above, at 8:15 A. m.
The CAUSE OF DEATH* was as follows:
Mitral regurgitation
& Chronic Nephritis
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical & Clinical

(Signed) J. O. Hemingway, M. D.
May 11, 1929 (Address) Blackfoot. Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Thomas Cemetery	5-19-29 19
20. Undertaker	Address
Modern Mortuary	Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66124

PLACE OF DEATH

County of Bingham

City of Blackfoot. Ida.

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 99

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert C. McDonald,

183

(a) Residence. No. Blackfoot. Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Cora B. McDonald,

6. DATE OF BIRTH (month, day and year): July, 30, 1866

7. AGE: 62 Years | Months: 10 | Days: 13 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Groceryman

(b) General nature of industry, business, or establishment in which employed (or employer): Mercantile

(c) Name of employer: Owner.

9. BIRTHPLACE (city or town) (State or country): Minn.

PARENTS

10. NAME OF FATHER: Thomas McDonald,

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Susan Good,

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio.

14. Informant: Cora B. McDonald
(Address) Blackfoot. Ida.

15. Filed May 15, 1929 Wm Walter E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May. 13., 1929. 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Accidental gun shot wound.

Verdict of Coroners Jury.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Ray McClellan, M. D.

5/15/29 19..... (Address) Coroner of Bingham County

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cem. Blackfoot, Ida.

Date of Burial: 5-16-29 19

20. Undertaker: Modern Mortuary,

Address: Blackfoot, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66125

PLACE OF DEATH
County of Bingham
City of Shelley Rt. #1

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 98
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stevens Joshua Cook
(a) Residence. No. Jamestown Idaho 1000
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Cook wife

6. DATE OF BIRTH (month, day and year) August 28 1879

7. AGE Years 49 Months 8 Days 18 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Gooseberry Utah

PARENTS
10. NAME OF FATHER Isaac Cook
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Miss Holden
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant J. L. Cook
(Address) Shafter Nevada

15. Filed May 12, 1929 Mrs Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1929, to May 8, 1929
that I last saw him alive on May 8, 1929
and that death occurred, on the date stated above, at 6 05 P m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) F. G. Roberts, M. D.
May 8, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Taylor, Idaho — Date of Burial May 12 1929

20. Undertaker [illegible] A Wood — Address Idaho Falls

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66126

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 97
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME T. M. Patty

(a) Residence. No. ..... St. 74a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE
4. COLOR OR RACE WHITE
5. Single, Married, Widowed, or Divorced (write the word) SINGLE

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 76 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer ---

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS
10. NAME OF FATHER ---
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ---
12. MAIDEN NAME OF MOTHER ---
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ---

14. Informant James M. Allen Att.
(Address) Blackfoot, Idaho

15. Filed May 8, 1929 Mrs Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 7th, 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1928, 19 to May 7th 1929, 19
that I last saw him alive on May 7th 1929, 19
and that death occurred, on the date stated above, at 6:45 P m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage, apoplexy
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
May 7th, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grove City Cem. | Date of Burial 19

20. Undertaker C. Varley | Address Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

PLACE OF DEATH

County of Bingham

City of Blackfoot

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 66127

Local Registrar's No. 96

2. FULL NAME Newel A. Booth

(a) Residence. No. RF 4 3 St. 880
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sep 30 1885

7. AGE: Years 43, Months 7, Days 6. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): St Charles Idaho

PARENTS

10. NAME OF FATHER: Massiah Booth

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Ambrosine Hibbert

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Lorenzo Booth
(Address) St. Charles Idaho

15. Filed May 8, 1929 McCalter E Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 6, 1929 that I last saw him alive on May 6, 1929 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

..... (duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) F. W. Mitchell, M. D.

5/7, 1929 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fish Haven — Date of Burial: May 10, 1929

20. Undertaker: E J Peck — Address: Blackfoot

RECEIVED JUN 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66128

PLACE OF DEATH
County of Buchanan
City of Sterling

Registration District No. 116
Primary Registration District No. 2195
(No.)

Local Registrar's No. 34

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Infant Christensen

(a) Residence. No. Sterling, Idaho St. 1610

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 9 1929

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or 30 min.
—	—	—	0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sterling, Ida

PARENTS

10 NAME OF FATHER David Christensen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sterling, Idaho

12 MAIDEN NAME OF MOTHER Eva Parmenter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Grand Valley, Colorado

14 Informant Ellen Claunch

(Address) Sterling Idaho

15 Filed 5/10, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 9, 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1929, to May 5, 1929, that I last saw h[illegible] alive on May 5, 1929, and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows: Premature - 28 week of gestation

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Premature Surgeon, M. D.

May 9, 1929 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Aberdeen Ida	May 10 1929

20. Undertaker Friends — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66129

PLACE OF DEATH

County of Lincoln
City of Aberdeen
Registration District No. 116
Primary Registration District No. 2195
Local Registrar's No. 23
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Alvira Permilla Hula

(a) Residence. No. Aberdeen, Idaho St. 36
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND ~~of~~
~~(or) WIFE of~~ Arum Hula

6 DATE OF BIRTH (month, day and year) Jan. 21. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Shelbyville, Indiana

PARENTS

10 NAME OF FATHER Omar Hula

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Phoebe Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indiana

14 Informant Dora E. Abercrombie
(Address) Aberdeen, Ida.

15 Filed May 6, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 5, 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Apl 11, 1929, that I last saw her alive on Apl 11, 1929, and that death occurred, on the date stated above, at 10:30 p. m.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Kidney
(duration) 1 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Chronic Cardiis
Was cular-renal disease & Hypertension
(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No Laboratory X. Ray
What test confirmed diagnosis?
(Signed) [signature], M. D.
May 6, 1929 (Address) Aberdeen, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Aberdeen, Idaho	5-7 1929
20. Undertaker	Address
Mr. Davis	American Falls, Ida

CUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66130

PLACE OF DEATH
County of Bingham
City of Shelley
Registration District No. 116
Primary Registration District No. 2 193
Local Registrar's No.
(No. 88 b)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ann Jones
(a) Residence. No. Sterling St. Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas L Jones

6. DATE OF BIRTH (month, day and year) July 14 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	67	8	26	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Woodland Cal.

PARENTS

10. NAME OF FATHER John Hale
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Bennett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Thomas L Jones
(Address) Sterling Ida

15. Filed Ap 4 29 M. C. Mortensen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1929 to April 3, 1929
that I last saw her alive on Ap 2, 1929
and that death occurred, on the date stated above, at 1.30 P. m.
The CAUSE OF DEATH* was as follows:
Myocarditis, Chronic
(duration) 6 yrs. - mos. - ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) M. C. Mortensen, M. D.
Ap 3, 1929 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kaysville Utah	Ap 6 1929

20. Undertaker E J Peck Address Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66131

PLACE OF DEATH
County of Blaine
City of Bellevue

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 23
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74

RECEIVED JUN 3 1929

2. FULL NAME Charlott Hubbs

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6. DATE OF BIRTH (month, day and year): 13-Sept-1841

7. AGE: Years 87, Months 8, Days 9. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Jacksonville Illinois

PARENTS

10. NAME OF FATHER: Charles Jameson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Mary Hedrick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): X

14. Informant: Mary C. Turner
(Address): Bellevue - Ida.

15. Filed 6-1, 1929 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22, 1929, to May 22, 1929
that I last saw her alive on May 22, 1929
and that death occurred, on the date stated above, at 7 a. m.
The CAUSE OF DEATH* was as follows:
Apoplexy
Hypertension B.P. 260
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
5/23, 1929 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bellevue Idaho. Date of Burial: May 24 1929

20. Undertaker: Harris & Amos E 244 Address: Hailey - Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66132

PLACE OF DEATH
County of Blaine
City of Bellevue

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22

RECEIVED JUN 3 1929
88 Fox

2. FULL NAME Seaman Arthur Barnes

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Vesta Barnes

6. DATE OF BIRTH (month, day and year): July 13 - 1878

7. AGE: Years 50, Months 10, Days 8. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Woodland Calif

PARENTS

10. NAME OF FATHER: John Wm Barnes
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Nova Scotia
12. MAIDEN NAME OF MOTHER: Bertheni Jarvis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): North Carolina

14. Informant: Vesta Barnes.
(Address): Bellevue Ida.

15. Filed 6 - 1, 1929 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1929, to May 22, 1929
that I last saw him alive on May 22, 1929
and that death occurred, on the date stated above, at 4.30 P. m.
The CAUSE OF DEATH* was as follows:
Myocarditis from Rocky Mountain Sick (Mottled) fever (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Bellevue, Ida
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) E. W. Fox, M. D.
5/23, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bellevue Idaho. Date of Burial: May 25 1929

20. Undertaker: Harris & Amos E 244 Address: Hailey - Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66133

PLACE OF DEATH
County of Blaine
City of Carey

Registration District No. 57
Primary Registration District No. 2025
(No. 2050)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 21

2. FULL NAME Sarah E. Carey

RECEIVED JUN 3 1929

(a) Residence. No. ..... St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 23—1852

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
76	11	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Utah
(State or country)

PARENTS

10. NAME OF FATHER Martin Hindmarsh

11. BIRTHPLACE OF FATHER (city or town) X
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Whaler

13. BIRTHPLACE OF MOTHER (city or town) X
(State or Country)

14. Informant Alice Carey Jessop
(Address) Carey Ida.

15. Filed 6-4-, 1929 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Never had a Doctor.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Robert H. Wright M. D.
5-12-, 1929 (Address) Co. Coroner Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Carey Idaho	May 13 1929
20. Undertaker E 244	Address
Harris & Amos	Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66134

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

1010

RECEIVED JUN 3 1929

2. FULL NAME Mary Gray
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 5 - 1866

7. AGE: 63 Years, Months: 3, Days: 4, If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Cairo Illinois

PARENTS
10. NAME OF FATHER: Levi Young
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill
12. MAIDEN NAME OF MOTHER: Anna Young England
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: S. L. George
(Address): Hailey, Idaho

15. Filed 6-1, 1929 R. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/4, 1929, to 5/8, 1929
that I last saw her alive on 5/8, 1929
and that death occurred, on the date stated above, at 1.10 P. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary) Uremia
..... (duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) E. W. [illegible], M. D.
5/9, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cremation Portland Ore
Date of Burial: May 13 1929

20. Undertaker: Harris & Amos E244
Address: Hailey, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66135

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 19

(No.) (If death occurred in a hospital or institution, give its name instead of street and number)

RECEIVED JUN 8 1929

2. FULL NAME Donald A. Cameron

(a) Residence. No. 102 Bright St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary J. Cameron

6. DATE OF BIRTH (month, day and year) Dec 9-1882

7. AGE	Years	Months	Days	If LESS than 1 day,
	46	4	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer

9. BIRTHPLACE (city or town) Aspen Colo.
(State or country)

PARENTS
10. NAME OF FATHER Hugh Thomas Cameron
11. BIRTHPLACE OF FATHER (city or town) Pictou, Nova Scotia
(State or Country)
12. MAIDEN NAME OF MOTHER Flora Mc Kinnon
13. BIRTHPLACE OF MOTHER (city or town) Pictou, Nova Scotia
(State or Country)

14. Informant Mary J. Cameron
(Address) Hailey Ida.

15. Filed 6-1, 1929 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-1, 1929, to 5-7, 1929
that I last saw him alive on 5-7, 1929
and that death occurred, on the date stated above, at 5:30 P m.
The CAUSE OF DEATH* was as follows:
Lung abscess

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. 3 weeks mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Robert H. Wright M. D.
5/8, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey Ida	May 11 1929

20. Undertaker E244 Harris & Amos — Address Hailey Ida

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66136

PLACE OF DEATH

County of Bonner

City of Priest River

Registration District No. 85

Primary Registration District No. 2185

Local Registrar's No. 17

(No. 44)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna L. Olson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 27 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Olson

6. DATE OF BIRTH (month, day and year) Feb. 16, 1869

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	3	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Ostnoro, (State or country) Sweden

PARENTS

10. NAME OF FATHER Mr. Anderson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Pete Olson
(Address) Priest River, Ida.

15. Filed June 3, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 31, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 12 M. m.
The CAUSE OF DEATH* was as follows:
Unknown Probable cancer of Stomach

(duration) 4 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. A. Moon - Coroner.

June 1, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I. O. O. F. Cemetery	June 3, 1929

20. Undertaker ... Address ...
Moon Mortuary Priest River

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66137

PLACE OF DEATH

County of Bonner

City of Priest River

Registration District No. 85

Primary Registration District No. 2185

Local Registrar's No. 16

(No. 170)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Nelson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) November 15, 1875

7. AGE	Years	Months	Days	If LESS than 1 day,
	53	5	23	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Lumbering

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Robt. Dow

(Address) Priest River, Ida

15. Filed May 14, 1929 R. E. Wessa
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
About May 8, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Suicide by Firearms.
Head blown off with shotgun

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) A. L. Moon Coroner

May 14, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I. O. O. F. Cemetery	May 14, 1929
20. Undertaker	**Address**
R. E. Wessa	Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66138

PLACE OF DEATH

County of Bonner

City of Priest River

Registration District No. 85

Primary Registration District No. 2185

Local Registrar's No. 15

(No. 100 N)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dorothy Eleanor Brooke

(a) Residence. No. St.
(Usual place of abode). (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) November 24, 1922

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	5	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minneapolis, Minn.

PARENTS

10. NAME OF FATHER F. G. Brooks

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Girard, Kans.

12. MAIDEN NAME OF MOTHER Agnes F. Bullis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Northfield, Minn.

14. Informant Fred L. Brooks
(Address) Priest River Idaho.

15. Filed May 6, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1929, to May 5, 1929,
that I last saw her alive on May 5, 1929,
and that death occurred, on the date stated above, at 6 00 P m.
The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Defective child since birth
Aphonia, paralysis of limbs since birth
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) C. L. Dobby M. D.

May 6, 1929 (Address) Priest River

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Woodmen Cemetery	May 7, 1929
20. Undertaker	Address
Moon Mortuary	Priest River

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66139

Registration District No. 85
Primary Registration District No. 2185
Local Registrar's No. 14

PLACE OF DEATH

County of Bonner
City of Nordman
(No. 170)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Feder

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6. DATE OF BIRTH (month, day and year) July 3, 1874

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54	10	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber

(c) Name of employer

9. BIRTHPLACE (city or town) Alsace, (State or country) Germany

PARENTS

10. NAME OF FATHER Charles Feder

11. BIRTHPLACE OF FATHER (city or town) Unknown (State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country)

14. Informant Naturalization Papers
(Address) Beaverhead County, Montana.

15. Filed May 6, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 4, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at about 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Suicide by Firearms
Shot through head

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) L. A. Moon Coroner ~~M. D.~~
May 5, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F. Cemetery	May 6, 1929
20. Undertaker R. E. Wessa	Address Priest River
Moon Mortuary	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66140

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles J Shoemaker

(a) Residence. No. 501 S Second St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

91 b

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Vivian Shoemaker

6. DATE OF BIRTH (month, day and year) Mar 29 1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	3	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Postmaster
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Chas D Shoemaker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Sophia Horner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Chas J Shoemaker
(Address) Sandpoint Idaho

15. Filed June 1, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1927, to May 30, 1929
that I last saw him alive on May 30, 1929
and that death occurred, on the date stated above, at 2:30 P. m.
The CAUSE OF DEATH*· was as follows:
Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical

(Signed) C. F. Payne, M. D.
June 1, 1929 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Coeur d Alene Idaho	June 2 1929
20. Undertaker: Turnbull Co	Address: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 7 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66141

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joshua E. Peterkin

(a) Residence. No. St. 98
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 40 yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Parnell Hospital
(Address) Sandpoint, Idaho.

15. Filed May 25, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 25, 1929
that I last saw him alive on May 24, 1929
and that death occurred, on the date stated above, at 4.17 m.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease
Chronic interstitial nephritis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Floyd G. Wenck, M.D.
May 25, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Priest River, Idaho.	May 28 1929
20. Undertaker	Address
R. E. Wessa	Priest River, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66142

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No. Rau Ranch North of Town.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Herman Ernest Rau.

(a) Residence. No. Sandpoint Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

194

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Bents Rau

6. DATE OF BIRTH (month, day and year) May 24, 1865.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	11	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Ed Rau
(Address) Sandpoint, Idaho

15. Filed May 24, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 22 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Homicide by blow on head with hammer and by cutting of throat, with cutting instrument.

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

.....(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) L. G. Moon. Coroner.
May 23, 1929 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	May 24, 1929
20. Undertaker	Address
Moon Mortuary	Sandpoint, Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66143

PLACE OF DEATH
County of Bonner
City of Sandpoint (rural)
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas George Twitchell

(a) Residence. No. Near Pack River School St.
(Usual place of abode)
Length of residence in city or town where death occurred. 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E Twitchell

6. DATE OF BIRTH (month, day and year) Dec 6 1886

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	5	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wye

PARENTS

10. NAME OF FATHER Henry F Twitchell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Mina Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mary E Twitchell
(Address) Pack River

15. Filed May 22 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Died not attended
that I last saw h alive on 5 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis effecting chiefly right ventricle. (Fibrous) Thrombosis
(duration) 4 yrs 1 mos 11 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Floyd Gillespie, M. D.
May 22, 1929 (Address) County Physician Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	5/27 1929
20. Undertaker	Address
Turnbull Co	Sandpoint, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66144

PLACE OF DEATH
County of Bonner
City of Dover

Registration District No. 78
Primary Registration District No. 2155
(No. 182)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Albert Wade

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 24, 1919.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	10	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) Public School
(c) Name of employer

9. BIRTHPLACE (city or town) Wilhoit
(State or country) Oregon

PARENTS

10. NAME OF FATHER Napoleon Wade

11. BIRTHPLACE OF FATHER (city or town) Wilhoit
(State or Country) Oregon

12. MAIDEN NAME OF MOTHER Anna Crite

13. BIRTHPLACE OF MOTHER (city or town) Colorado
(State or Country)

14. Informant James B. Atkins
(Address) Dover, Idaho.

15. Filed May 25, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 11th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Accidental Drowning

.....(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
.....(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) L. A. Moon. Coroner
May 25, 1929 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	May 26, 1929
20. Undertaker	Address
Moon Mortuary	Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66145

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No. Sandpoint Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hans C. Foss

(a) Residence. No. Sandpoint, Idaho St. 88 b
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Gunhild Foss

6. DATE OF BIRTH (month, day and year): Jan. 30, 1853.

7. AGE: Years 76 | Months 3 | Days 8 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Mill Wright (retired)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10. NAME OF FATHER: Christopher Fossen.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Victor Foss
(Address) Sandpoint, Idaho.

15. Filed May 9, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 8, 1929. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1929, to May 6, 1929

that I last saw him alive on May 3, 1929

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

[illegible]

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible], M. D.

May 10, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery

Date of Burial: May 10, 1929

20. Undertaker: Moon Mortuary

Address: Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66146

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME HANNAH ROWE

(a) Residence. No. St. 74a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jacob Rowe

6. DATE OF BIRTH (month, day and year) Jan. 26th. 1841

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	3	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10. NAME OF FATHER ---- Musselman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant J. F. Sauer
(Address) Sandpoint, Idaho.

15. Filed May 9, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 7th. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to May 7th, 1929
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 9.45 a.m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 12 hours yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) W. B. Evans, M. D.
May 8, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	May 9, 1929
20. Undertaker	Address
MOON MORTUARY	SANDPOINT? IDA.

Evans RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66147

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. 519 Cedar Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME William Kent Fury
(a) Residence. No. Sagle, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

3 ✓

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 1, 1925

7. AGE: Years 4, Months 2, Days 4. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sagle, Idaho

PARENTS

10. NAME OF FATHER Robert A. Fury,
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ontario, Canada.
12. MAIDEN NAME OF MOTHER Katherine Ellen Futy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Robert A. Fury.
(Address) Sagle Idaho.

15. Filed May 7, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5, 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31st, 1929, to April 5, 1929
that I last saw him alive on April 4th, 1929
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:
Tubercular Meningitis
(duration) yrs. One mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Spinal fluid - microscopic
(Signed) R. B. Evans M. D.
5 - 7, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Westmo nd Cemetery
Date of Burial: May 7, 1929

20. Undertaker: Moon Mortuary
Address: Sandpoint Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66148

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 880

2. FULL NAME Louis Venette

(a) Residence. No. Sandpoint Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day ~~and year~~) Obtainable

7. AGE

Years	Months	Days	If LESS than 1 day,
73	—	—	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work woodsman
(b) General nature of industry, business, or establishment in which employed (or employer) Humbird Lbr Co
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Paris France

PARENTS

10. NAME OF FATHER unobtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country) France
12. MAIDEN NAME OF MOTHER unobtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) France

14. Informant Page Hospital
(Address) Sandpoint Ida

15. Filed May 6, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2, 1929, to May 4, 1929
that I last saw h~~e~~ alive on May 4, 1929
and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:
Chronic endocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) arterio-sclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) C. F. Page, M. D.
May 7, 1929 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview C	5/8 1929
20. Undertaker	Address
Tunnell Co	Sandpoint.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66149

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No. 614 Pine Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Helen Marguerite Rauer

(a) Residence. No. 614 Pine street St. 117
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) November 4, 1911.

7. AGE: Years 17, Months 5, Days 29. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Louis Rauer

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Anna Harty

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New Boston Missouri

14. Informant: Louis Rauer
(Address) Sandpoint, Idaho.

15. Filed May 5, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 3, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2, 1929, to May 2, 1929 that I last saw her alive on May 2, 1929 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows: Peritonitis Ac. Appendicitis Due to patients ~~reg~~ religion case was neglected for 1 week.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) , M. D.

May 5, 1929 (Address) R. J. Ross. Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pinecrest Cemetery — Date of Burial: May 5, 1929

20. Undertaker: Moon Mortuary — Address: Sandpoint, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66151

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

88 K

2. FULL NAME Perry F. Mann

(a) Residence. No. 1003 Michigan Ave St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Mann

6. DATE OF BIRTH (month, day and year) May 17, 1848

7. AGE Years 80 Months 11 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Merchant

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winchester Indiana

PARENTS

10. NAME OF FATHER Thomas Emery Mann

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Wilma Newton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Dr. N. A. Mann
(Address) Portland, Oregon.

15. Filed May 3, 1929 Viola Aller Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1929, to April 23, 1929

that I last saw him alive on April 23, 1929

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis Vascular disease Embolism of popliteal artery

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. E. Roy, M. D.

May 3, 1929 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pinecrest Cemetery — Date of Burial: May 3, 1929

20. Undertaker: Moon Mortuary — Address: Sandpoint, Ida

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66152

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1-29

2. FULL NAME Sarah Bartlett

(a) Residence. No. Parnell Hospital St.
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6. DATE OF BIRTH (month, day and year) Sept. 19, 1841

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	7	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Parnell
(Address) Sandpoint, Idaho

15. Filed May 6, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 4, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Gangrene
Senile Debility
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Floyd G. Wardle, M. D.
May 6, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
~~Pinecrest Cemetery~~ Athol, Idaho	May 6, 1929
20. Undertaker	Address
Moon Mortuary	Sandpoint, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66153

RECEIVED MAY 16 1929

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 14-0
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 71

2. FULL NAME Parley Lowe

(a) Residence. No. ..... St. 44
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 19 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho.

PARENTS

10. NAME OF FATHER: R D Lowe
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ?
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

14. Informant: J A Wheeler
(Address) Mareland Idaho

15. Filed Mar 30, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30, 1929, to March 30, 1929
that I last saw him alive on March 30, 1929
and that death occurred, on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Epidemic Spinal Meningitis
..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Blackfoot
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Spinal puncture
(Signed) [signature], M. D.
3/31, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mareland Idaho | Date of Burial: [signature] 1929

20. Undertaker: E F Peck | Address: Blackfoot

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66154

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 12
Primary Registration District No. 2-10-0
Local Registrar's No. 2
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myrtle Jolline Porter

(a) Residence. No. ..... St. Firth, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 2, 1928

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER Harold Porter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Myrtle Christensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Goshen, Idaho

14. Informant Mrs. Andrew Christensen
(Address) Firth, Idaho

15. Filed May 3, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-1, 1929, to 4-1-, 1929
that I last saw h[illegible] alive on 4-1-, 1929
and that death occurred, on the date stated above, at 10 -a m.
The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis
(duration) yrs. mos. 10hs ds.

CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At Firth
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Lab Ex. Spinal Fluid
(Signed) Edwin Cahlin, M. D.
4-2-, 1929 (Address) Shelley.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Basalt, Idaho	April 2 1929
20. Undertaker	Address
Jack A. Wood	Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66156

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2170

Local Registrar's No. 74

(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Herbert Rex Hoskins

(a) Residence. No. ..... St. Blackfoot, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 31, 1929

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
4	10	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Blackfoot, Idaho

PARENTS

10. NAME OF FATHER: Josiah H. Hoskins

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Tillie Clark

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Mr. Josiah H. Hoskins
(Address) Blackfoot, Idaho

15. Filed Apr 4, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 8, 1929 that I last saw him alive on Apr. 3, 1929 and that death occurred, on the date stated above, at 8-30p m.

The CAUSE OF DEATH* was as follows: Epidemic Cerebro Spinal Meningitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Same

(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? Blackfoot Id.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Spinal Fluid

(Signed) [signature], M. D.

4-4, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Blackfoot, Idaho

Date of Burial: April 5 1929

20. Undertaker: J.A. Wood

Address: Idaho Falls

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66157

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
Local Registrar's No. 74

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1610

2. FULL NAME Dewane Dearden

(a) Residence. No. 178-13 St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 12 hrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): April 4-29.

7. AGE: Years: no; Months: no; Days: no; If LESS than 1 day, 12 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls. Idaho.

PARENTS

10. NAME OF FATHER: Leslie Dearden
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Morgan Utah.
12. MAIDEN NAME OF MOTHER: Lillian Lees.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kimmer Wyo.

14. Informant: Leslie Dearden.
(Address) Idaho Falls Ida.

15. Filed: [illegible], 1929. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4, 1929, to April 4, 1929
that I last saw her alive on April 4, 1929
and that death occurred, on the date stated above, at 6 30 P. m.
The CAUSE OF DEATH* was as follows:
Premature Infant.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Harry L. Willson, M. D.
4/5, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: 4/5 1929

20. Undertaker: V. F. McHan Address: Idaho Falls Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 16 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66158

Registration District No. 73

Primary Registration District No. 2170

Local Registrar's No. 76

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rose Marie Earl

(a) Residence. No. Parker St. 10

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 5th 1927

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	11	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Brookland N. Y.

PARENTS

10. NAME OF FATHER Eugene Earl

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Plymouth Utah

12. MAIDEN NAME OF MOTHER Ester Marie Thompson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Ester Marie Earl

(Address) Parker Ida

15. Filed Apr 6, 1927 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 3 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3, 1929, to April 3, 1929 that I last saw her alive on April 3, 1929 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? St Anthony Ida

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) [signature], M. D.

Apr 5, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Parker Ida

Date of Burial [signature] 1929

20. Undertaker [signature] Address St Anthony Ida

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66159

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 23
Primary Registration District No. 2150
(No.)

Local Registrar's No. 77

(If death occurred in a hospital or institution, give its name instead instead of street and number)

2. FULL NAME Harriet Marie Kartchner

(a) Residence. No. 146 Driggs Idaho St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jas. A Kartchner

6 DATE OF BIRTH (month, day and year) Oct 9 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	24	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Logan Utah

PARENTS

10 NAME OF FATHER John L. Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Logan Utah

12 MAIDEN NAME OF MOTHER Armina J Parry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Salt Lake City Utah

14 Informant J. A Kartchner
(Address) Driggs Idaho

15 Filed Apr 6, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 5 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mch 12, 1929, to April 5, 1929, that I last saw her alive on April 5, 1929, and that death occurred, on the date stated above, at 8" P m.

THE CAUSE OF DEATH* was as follows:

Primary Septicemia follow.
General Septicemia follow.
Living version of a placenta
Prava 7 months
(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Pneumonia Septic
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Driggs Ida

Did an operation precede death? yes Date of Mar 5 1929

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

April 5, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Ft. Logan Utah — Date of Burial 4/7 1929

20. Undertaker V. F. McHan — Address Idaho Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66160

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

CERTIFICATE OF DEATH

Registration District No. 73
Primary Registration District No. 2 IV-0
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 7 F

2. FULL NAME Byron Armon Wheeler

(a) Residence. No. Blackfoot Ida St. 118 W
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug. 29-1900

7 AGE Years 28 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farm Hand
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Peter G Johnston

9 BIRTHPLACE (city or town) (State or country) Blackfoot Idaho

PARENTS
10 NAME OF FATHER John W. Wheeler
11 BIRTHPLACE OF FATHER (city or town) (State or country) Iowa
12 MAIDEN NAME OF MOTHER Charlotte Dousie
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah

14 Informant C M Cline
(Address) Idaho Falls Idaho

15 Filed Apr 10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 9 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 6, 1929, to Apr 9, 1929, that I last saw him alive on April 8, 1929, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:
Partial Obstruction ileum
(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) General Peritonitis
(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Blackfoot Ida
Did an operation precede death? Yes Date of Apr 7/29
Was there an autopsy? No
What test confirmed diagnosis? [illegible]
(Signed) [signature] M. D.
April 9, 1929 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Blackfoot Ida
Date of Burial: April 1929

20. Undertaker: Modern Mortuary
Address: Blackfoot Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66161

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 79
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gladys May Mansfield.
(a) Residence. No. ..... St. 710
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 11 yrs. 11 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE: Years 11, Months 11, Days 18. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Iona Idaho

PARENTS
10. NAME OF FATHER: John Mansfield.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England.
12. MAIDEN NAME OF MOTHER: Charlotte Berry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mercur Utah.

14. Informant: John Mansfield.
(Address): Iona Idaho.

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/11, 1929, to 5/12, 1929
that I last saw her alive on ....., 19..
and that death occurred, on the date stated above, at 420 P.m.
The CAUSE OF DEATH* was as follows:
Meningitis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D. Sutton, M. D.
5/13/29, 19.... (Address) Ida Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Iona Idaho. Date of Burial: May 3 1929
20. Undertaker: W. F. McHan. Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66162

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2100
Local Registrar's No. 21
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Street
(a) Residence. No. St. 148
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wid Street
6. DATE OF BIRTH (month, day and year) April 7-1900
7. AGE Years 29 Months 0 Days 2. If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Chesterfield Idaho
PARENTS
10. NAME OF FATHER A. Pedersen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Flora E. Fowlke
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lincoln Utah
14. Informant Mr A. Pedersen
(Address) Idaho Falls Ida
15. Filed April 11, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 9 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 30, 1929, to April 9, 1929
that I last saw her alive on April 8, 1929
and that death occurred, on the date stated above, at 1.35 A m.
The CAUSE OF DEATH* was as follows:
Eclampsia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pregnancy
(duration) yrs. 8 mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of April 3-29
Was there an autopsy? No
What test confirmed diagnosis? Symptoms = Minalysis
(Signed) H. D. [signature], M. D.
April 10, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls Ida. Date of Burial 4/17 1929
20. Undertaker V. F. McHan Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66163

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2150

Local Registrar's No. 2

(No. L 16 S Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Hart

(a) Residence. No. Roberts Ida St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

88 b

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) ? Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 75 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER ? Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ? Unknown

12. MAIDEN NAME OF MOTHER ? Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ? Unknown

14. Informant Wm Newton Tebbs
(Address) Hayes Und Co Ida Falls Ida.

15. Filed April 12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18, 1929, to April 10, 1929
that I last saw him alive on April 10, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Aortic Insufficiency
Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? Roberts Idaho

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms-Physical

(Signed) H D Jenkins, M. D.

April 12, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls

Date of Burial Apr 12 1929

20. Undertaker Cliff C Hayes

Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 16 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66164

Registration District No. 73

Primary Registration District No. 2150

Local Registrar's No. F 3

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas. J. Wright

(a) Residence. No. ..... St. 111 8

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 18 - 1861

7. AGE: Years 68 Months 10 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Joplin Mo

PARENTS

10. NAME OF FATHER: Dent Knox

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Dent Knox

12. MAIDEN NAME OF MOTHER: Dent Knox

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dent Knox

14. Informant: Walter L. Wright

(Address) Box 364 Blackfoot Idaho

15. Filed April 14, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9, 1929, to Apr 13, 1929

that I last saw him alive on Apr 13, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Perforated Duodenal Ulcer

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary): Peritonitis

(duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? Blackfoot

Did an operation precede death? Yes Date of April 10

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

....., 19.... (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Green City Cemetery

Date of Burial: April 17 1929

20. Undertaker: E J Peck

Address: Blackfoot

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66165

Local Registrar's No. 4

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 23
Primary Registration District No. 2170
(No. Spencer Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thelma M Fowler

(a) Residence. No. Driggs Ida St. 117
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 31 —

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	16			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah. Idaho.

PARENTS

10. NAME OF FATHER Ira R Fowler.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Lillian McClanahan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant Ira R Fowler.
(Address) Driggs Ida

15. Filed Apr 16, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 —, 1929, to April 14, 1929
that I last saw h[illegible] alive on April 7 —, 1929
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:
appendicitis Peritonitis
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Driggs Idaho
Did an operation precede death? Yes Date of April 7 1929
Was there an autopsy? Yes No
What test confirmed diagnosis? C
(Signed) [illegible] M. D.
April 15 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Driggs Ida	Apr. 1929

20. Undertaker Cliff Hayes Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66166

Registration District No. 73
Primary Registration District No. 2179
Local Registrar's No. 45

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
(No. St. Anthony's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marjorie Jean Donnelly

(a) Residence. No. 219 Lava St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Mar 11-1926

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3	1	7	—

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Nampa Idaho

PARENTS

10. NAME OF FATHER Leslie Donnelly
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wakefield Iowa
12. MAIDEN NAME OF MOTHER Sarella
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ida. Falls Ida

14. Informant Leslie Donnelly
(Address) 219 Lava Ida. Falls Ida.

15. Filed Apr 20, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April-16, 1929, to April 18, 1929
that I last saw h[illegible] alive on April 18, 1929
and that death occurred, on the date stated above, at 9 [illegible] m.
The CAUSE OF DEATH* was as follows:
Ileo-Colitis - Intestinal-
toxemia
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) [signature], M. D.
Apr 20, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho	April 21 1929
20. Undertaker	Address
Jack G. Wood	Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66167

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

2. FULL NAME Louisa Hudman

(a) Residence. No. Idaho Falls Route #5 St. 117
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Orson S. Hudman

6. DATE OF BIRTH (month, day and year) September 7, 1869

7. AGE: Years 60 Months 7 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden, Utah

PARENTS
10. NAME OF FATHER William Wheeler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Martha Howe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant Mr. Orson S. Hudman
(Address) Idaho Falls Route #5

15. Filed Apr 27, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20, 1920, to Apr 25, 1929
that I last saw her alive on April 25, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Appendicial Abscess & Peritonitis
(duration) yrs. mos. 30 ds.
CONTRIBUTORY (Secondary) Cancer of Corcum
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Rt. #5
Did an operation precede death? Yes Date of Mar 25
Was there an autopsy? Yes
What test confirmed diagnosis? Examination
(Signed) [signature], M. D.
4/26, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho — Date of Burial: April 28 1929

20. Undertaker: Jack A. Wood — Address: Idaho Falls

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66168

PLACE OF DEATH
County of Bonneville. Registration District No. 3
City of Idaho Falls Primary Registration District No. 2150 Local Registrar's No. 47
(No. County Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Frakes.

(a) Residence. No. 228 West 14 St. 44
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June

7. AGE: Years 67 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: janitor.
(b) General nature of industry, business, or establishment in which employed (or employer): at Eagles.
(c) Name of employer: Lodge.

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: Unknown.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown.
12. MAIDEN NAME OF MOTHER: Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown.

14. Informant: Eagles Lodge.
(Address): Idaho Falls. Ida.

15. Filed Apr 29, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/15/29, 19..., to 4/28, 1929
that I last saw him alive on ..., 1929
and that death occurred, on the date stated above, at 12 P m.
The CAUSE OF DEATH* was as follows: Carcinoma of Liver.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [signature], M. D.
4/29/29 1929 (Address) Ida Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: May 1 - 1929 | Date of Burial: Idaho Falls. 1929

20. Undertaker: V. L. F. McHan | Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66169

PLACE OF DEATH

County of Bonneville.
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. L. D. S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. AL

2. FULL NAME William Peart.
(a) Residence. No. 298 So Capitol Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

58a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 27-1925

7. AGE: 3 Years — 3 Months 10 Days 1 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ogden. Utah.

PARENTS

10. NAME OF FATHER: Robert A. Peart.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England.
12. MAIDEN NAME OF MOTHER: Lila Irene Burch.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Deer Lodge Mont.

14. Informant: Robert A. Peart.
(Address) 298 So Capitol Ave.

15. Filed Apr 29, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 22, 1929, to Apr 28, 1929
that I last saw him alive on ___, 19__
and that death occurred, on the date stated above, at 1230 P m.
The CAUSE OF DEATH* was as follows:
Pernicious Anemia
(duration) ___ yrs. 2 mos. ___ ds.

CONTRIBUTORY (Secondary)
(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Laboratory
(Signed) [signature], M. D.
___, 19__ (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ogden Utah. Date of Burial: May 1 1929.

20. Undertaker: V. F. McHan. Address: Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 16 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66170

Local Registrar's No. 27

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2 1/2
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Burton Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Sept (Month) 6 (Day) 1907 (Year)

7. AGE: 21 Yrs. 7 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Madison Co, Idaho

10. NAME OF Father: J. Alma Johnson

11. BIRTHPLACE OF FATHER (State or Country): Logan, Utah

12. MAIDEN NAME OF MOTHER: Maggie Sorensen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. Alma Johnson
(Address): Thornton, Idaho

15. Filed May 3, 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 1929. to April 31 1929
that I last saw him alive on April 30 1929
and that death occurred on the date stated above, at 6.40 A.M.
The CAUSE OF DEATH* was as follows:
Epidemic Cerebro Spinal Meningitis.
(Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. Ray Hatch M. D.
May 3 1929. (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton Cemetary — DATE OF BURIAL: May 3 1929

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66171

PLACE OF DEATH

County of Canyon,

City of Caldwell,

Registration District No. 3

Primary Registration District No. 2005,

Local Registrar's No. 27

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Ellison,

(a) Residence. No. Caldwell, Rural No. 2. St. 160
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single,

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April, 10-1929,

7. AGE Years | Months | Days | If LESS than 1 day, 5 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell, Idaho,

PARENTS

10. NAME OF FATHER J.E. Ellison, (Ellison,)

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa,

12. MAIDEN NAME OF MOTHER Eva Harris,

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri,

14. Informant Mrs. Lester Harris,
(Address) Caldwell, Idaho,

15. Filed 4-12-, 1929- John S. Meyer. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apl (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl 11, 1929, to Apl 11, 1929

that I last saw him alive on Apl 10, 1929

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

~~Prematurity~~

Aesthenia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S B Dudley M. D.

4/12 19 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill. Date of Burial: 4-12- 1929.

20. Undertaker: Father and Friends. Address: Caldwell. Idaho.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66172

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 28

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rebecca Jane Edwards. 164

(a) Residence. No. Caldwell #1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 13-1832

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
96	5	28.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Harrison Co.
(State or country) Ohio.

PARENTS

10. NAME OF FATHER S.W. Hamill.
11. BIRTHPLACE OF FATHER (city or town) Ireland.
(State or Country)
12. MAIDEN NAME OF MOTHER Sampson
13. BIRTHPLACE OF MOTHER (city or town) Ireland.
(State or Country)

14. Informant W.J. Edwards
(Address) Caldwell Ida

15. Filed 4-13-, 1929 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1925, to April 11, 1929
that I last saw h[er] alive on Mar - 20, 1929
and that death occurred, on the date stated above, at 8-45 a m.
The CAUSE OF DEATH* was as follows:
Old age - General
Decline -

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J.D. Foster M. D.
April 12, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill.	4-13 1929
20. Undertaker	Address
C.V. Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66173

PLACE OF DEATH

County of Canyon
City of Middleton
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 29
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

112

2. FULL NAME Mary Magdelene Bockhop

(a) Residence. No. Middleton St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): June 11-1844

7. AGE: Years: 84 | Months: 10 | Days: 2 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS
10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: J. W. Hamer M. D.
(Address) Middleton, Ida

15. Filed 4-17-1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11, 1929, to April 13, 1929, that I last saw her alive on 13th April, 1929, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:
Gastritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. W. Hamer, M. D.
April 15th 1929 (Address) Middleton, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Middleton	April 17 1929
20. Undertaker	Address
C. N. Peckham	Caldwell, Ida

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66174

PLACE OF DEATH
County of Canyon
City of Wilder

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 31
(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth A Rye

(a) Residence. No. Wilder, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 30-1844

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	0	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS
10. NAME OF FATHER Samuel Huntington
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Pearl Law
(Address) Wilder

15. Filed 4-20-, 1929 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from apr 16, 1929, to apr 18, 1929
that I last saw her alive on apr 17, 1929
and that death occurred, on the date stated above, at 6:30 P m.
The CAUSE OF DEATH* was as follows:
Old age (chronic Interstetial nephritis)

unknown (duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? Lab
(Signed) Roberts E Tallent M. D.
apr 20, 1929 (Address) Wilder Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wilder	April 20 1929
20. Undertaker C. V. Peckham	Address Caldwell, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66175

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 33

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ida Eastman Hays

(a) Residence. No. Middleton Ida St. 74a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Austin P. Hays

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 50 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10. NAME OF FATHER: Beatty
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant Austin P. Hays
(Address) Middleton Ida

15. Filed 4-21-, 1929- John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1929, to April 19, 1929
that I last saw her alive on April 19, 1929
and that death occurred, on the date stated above, at 4:10 P.m.
The CAUSE OF DEATH* was as follows:
Apoplexy

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
4/20, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill | Date of Burial: 4-21- 1929

20. Undertaker: C. V. Peckham | Address: Caldwell, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66176

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 34

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles B. Caldwell

(a) Residence. No. 600 Albany Caldwell St. Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

101 b

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 26-1865

7. AGE: Years 63, Months 11, Days 23. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Fountain Utah

PARENTS

10. NAME OF FATHER: Mathew Caldwell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Vermont
12. MAIDEN NAME OF MOTHER: Nancy B. Butler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: Mrs S. B. Gates
(Address) R#1 - Caldwell Idaho

15. Filed 4-24-, 1929. John S. Meyer - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15, 1929, to April 19, 1929
that I last saw him alive on April 19, 1929
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Pneumonia

..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary): Infection gall bladder
..... (duration) ..... yrs. Several mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
4/23, 1929 (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill. Date of Burial: April 24 1929

20. Undertaker: C. V. Peckham. Address: Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66177

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 35

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Martin

(a) Residence. No. R F D (Caldwell) St. 92
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 21 1851

7. AGE

Years	Months	Days	If LESS than 1 day,
78	3	1	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Minister M E Church.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ills

PARENTS

10. NAME OF FATHER Wm Martin

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Sara Martin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant George Martin

(Address) Homedale Idaho

15. Filed 4-25, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 22 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1928, to April 22, 1929

that I last saw him alive on April 20, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cardiac Embolis

..... (duration) ..... yrs. Sudden mos. ..... ds.

CONTRIBUTORY (Secondary) Endocarditis

..... (duration) Several yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [signature], M. D.

4/25, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fargo Cemetery

Date of Burial: Apr 25-29 19

20. Undertaker: Paul L. Case

Address: Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66179

RECEIVED MAY 15 1929

PLACE OF DEATH

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 37
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John F Ernst

(a) Residence. No. Odd Fellows Home St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 16 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	4	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Georgetown
(State or country) Ohio

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Viola H Price
(Address) Caldwell Idaho, I O O F Home

15. Filed 4-26-, 1929. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from —, 1927, to April 26, 1929
that I last saw him alive on April 26, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.
4/28, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	April 28-29
20. Undertaker	**Address**
Paul L. Case	Caldwell Idaho

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66180

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 38

PLACE OF DEATH
County of Canyon
City of Caldwell
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret A Miller

(a) Residence. No. 1622 Cleveland St. 880
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 4 1844

7. AGE: Years 84 | Months 6 | Days 23 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Delphos Ohio.

PARENTS
10. NAME OF FATHER: Charles Tindel
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Julia White
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Mrs Ella Miller
(Address) Caldwell Idaho

15. Filed 4-28-, 1929. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12, 1929, to April 27, 1929, that I last saw her alive on April 27, 1929, and that death occurred, on the date stated above, at 12:10 a m.

The CAUSE OF DEATH* was as follows:
Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms

4/27, 1929 (Signed) Jno. Dr. Endocarditis M. D. (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill. Date of Burial: April 28 1929

20. Undertaker: C. V. Peckham Address: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 1 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66181

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 39

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

182

2. FULL NAME Charlie Martin Frost

(a) Residence. No. Middleton St. Idaho

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 23 1906

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	--	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell Idaho

PARENTS

10. NAME OF FATHER M S Frost

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fairbury Ills

12. MAIDEN NAME OF MOTHER Rosa M. Thompson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Belleville Kans

14. Informant M S Frost

(Address) Middleton Idaho

15. Filed 4-29-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 27-29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Drowning, Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Paul L. Case Coroner, M. D.

, 19 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Star Idaho	Apr 29-29

20. Undertaker	Address
Paul .L.Case	Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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Oct 15-27
Jan 6-1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED MAY 15 1929

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66182

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 40

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maggie Lavina Bradt.
(a) Residence. No. Wilder #1 St. 44
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of C. W. Bradt.

6. DATE OF BIRTH (month, day and year) Feb-15-1870

7. AGE 59 Years | Months 2 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chicago Ill.

PARENTS

10. NAME OF FATHER J. F. Clough.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mass.
12. MAIDEN NAME OF MOTHER Helena Gesner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y. ~~Ill.~~

14. Informant C. W. Bradt
(Address) Wilder, Idaho

15. Filed 5-3-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6-, 1929 to May 2-, 1929
that I last saw her alive on May 2-, 1929
and that death occurred, on the date stated above, at 5-50 a.m.
The CAUSE OF DEATH* was as follows:
Gastric Carcinoma
(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X ray
(Signed) N. M. Kaley, M. D.
5-2-1929 (Address) Caldwell Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Canyon Hill
Date of Burial May 3 1929

20. Undertaker C. V. Peckham
Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66183

Local Registrar's No. 41

PLACE OF DEATH
County of Malheur.
City of Jordan Valley
Registration District No. 3
Primary Registration District No. 9005
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Harley Gess Jr. 182

(a) Residence. No. Homedale Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 19 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise Idaho.

PARENTS

10. NAME OF FATHER: W. H. Gess.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ada County Idaho
12. MAIDEN NAME OF MOTHER: Katherine Porter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Harrison Co. Iowa

14. Informant: W N Gess
(Address): Homedale Idaho

15. Filed 5-9-, 1929. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw him alive on May 4, 1929
and that death occurred, on the date stated above, at 12-15 P. m.
The CAUSE OF DEATH* was as follows:
Drowned in irrigating ditch when automobile overturned

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) W W Jones M. D.
May 7, 1929 (Address) Jordan Valley Oregon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill.	5-9 1929
20. Undertaker	Address
C. V. Peckham	Caldwell Idaho

RECEIVED MAY 15 '29

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66184

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
(No.)
Local Registrar's No. 42

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Elizabeth Noland Beatty

(a) Residence. No. 1022 Main st St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Swain Beatty

6. DATE OF BIRTH (month, day and year) May 8 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	11	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ills

PARENTS

10. NAME OF FATHER David Noland
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cork Ireland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Richard Beatty
(Address) Caldwell Idaho

15. Filed 5-8-, 1929. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 6 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Feb 11, 1929, to May 6, 1929
that I last saw h.. alive on May 6, 1929
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Septic Endocarditis
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Infected Scalp from Lacerahon (duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? In home.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) David E Baird, M. D.
May 7, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	May 8-29
20. Undertaker	Address
Paul L. Case	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66185

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 43

(No. 1610)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jack J. Shaffer

(a) Residence. No. 303 Blaine St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May - 6 - 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country)

PARENTS

10. NAME OF FATHER J. J. Shaffer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Caldwell Idaho
12. MAIDEN NAME OF MOTHER Della Shelton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pearl Idaho

14. Informant J. J. Shaffer
(Address) 303 Blaine Caldwell, Ida

15. Filed 4-11-1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May. 6, 1929, to May. 10, 1929
that I last saw him alive on May. 10, 1929
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Premature
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) David E Baird M. D.
May 10, 1929 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Star Cemetery	May - 11 - 1929
20. Undertaker C. V. Peckham	Address Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-A—25 RECEIVED JUN 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 2006

(No. ..... St.)

File No. 66186

Registered No. 71

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ted Pettyjohn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jany (Month) 14 (Day) 1914 (Year)

7. AGE: 15 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Centralia Wn

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mable E Wellman

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Don Poynter

(Address) Nampa Idaho

15. Filed May 31 1929 Bertha Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1929 (Year) 38

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1926, to May 30th 1929, that I last saw him alive on May 30th 1929, and that death occurred on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows:

Pyemia (Infection)

(Duration) ..... Yrs. 1 mos. 14 ds.

Contributory (Secondary) Syphilis (Herad.)

(Duration) since birth yrs. ..... mos. ..... ds.

(Signed) Don Poynter M. D.

5/30 1929 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: F. K. Robinson

ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66187

PLACE OF DEATH
County of Canyon
City of Huston

Registration District No. 7
Primary Registration District No. 2016
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 70

2. FULL NAME Teddy Johnson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 21 - 1924

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
5	—	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Huston Idaho
(State or country)

PARENTS

10. NAME OF FATHER Eri. L Johnson
11. BIRTHPLACE OF FATHER (city or town) Springville Utah
(State or Country)
12. MAIDEN NAME OF MOTHER Maude Gwilliam
13. BIRTHPLACE OF MOTHER (city or town) Ogden Utah
(State or Country)

14. Informant E. L. Johnson
(Address) Huston Idaho

15. Filed May 31, 1929. Lettie Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Accidental drowning -
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Paul L. Lease M. D.
5-30-29 19 (Address) Coroner Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Idaho	6-1 1929
20. Undertaker	Address
J. T. Robinson	Nampa Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66188

PLACE OF DEATH

County of Canyon

City of Nampa Ida

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 61

(No. Nazarene Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John F. Logue

(a) Residence. No. 220 - 14 Ave So. St. 129
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Willa.

6. DATE OF BIRTH (month, day and year): Sept 10, 1888

7. AGE: Years 40 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carman, C. S. L.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kan.

PARENTS

10. NAME OF FATHER: Oliver Logue.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Polly Murphy

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Willa Logue

(Address): Nampa

15. Filed 6/1, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 31 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1929, to May 31, 1929 that I last saw him alive on May 31, 1929 and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis.

(duration) Bad since Jan 1, 1929 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. R. Proctor M. D.

5-31-1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls. | Date of Burial 19

20. Undertaker: Wm D. Talley | Address: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66189

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1106
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 68

2. FULL NAME Joseph Reed Stanwood
(a) Residence, No. 403 - 4th St ~~St.~~ 129
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 22 - 1862

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
66	8	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Brick Mason
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Seward Nebr.

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Clyde Stanwood
(Address) Nampa, Idaho

15. Filed 5/16, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to May 16, 1929
that I last saw him alive on May 16, 1929
and that death occurred, on the date stated above, at 2 45 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial nephritis Tricuspid regurgitation
(duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical signs
(Signed) H. P. Ross M. D.
May 16, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Gooding Ida
Date of Burial: 19

20. Undertaker: F. K. Robinson
Address: Nampa

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66190

PLACE OF DEATH
County of Canyon
City of Nampa, Ida.

Registration District No. 7
Primary Registration District No. 1006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 67

205a

2. FULL NAME Mary Ellen Richardson
(a) Residence. No. 224-20 Ave So. St. 14 Months
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of H. H.

6. DATE OF BIRTH (month, day and year) Jan 17 1851

7. AGE Years 78 Months 4 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ore.

PARENTS

10. NAME OF FATHER Fields
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER Blanton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant H. H. Richardson
(Address) Nampa

15. Filed 5/25, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13, 1929, to May 21, 1929
that I last saw her alive on May 3, 1929
and that death occurred, on the date stated above, at 10:30 m.
The CAUSE OF DEATH* was as follows:
Exhaustion - bedridden from rheumatoid arthritis
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [illegible], M. D.
5-24, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kohlerlawn. Date of Burial 5/23 1929

20. Undertaker Wm D Talley. Address Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66191

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1916

Local Registrar's No. 66

(No. 170)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles L. Brumbaugh

(a) Residence. No. 407 18th Ave South St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 20 1888

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	9	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ry Yard Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer O S L Ry

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Harry Brumbaugh

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Charles L. Brumbaugh

(Address) 407 18th Ave So. Nampa Ida

15. Filed 5/20, 1929 Leslie Rumsey
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 18 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Revolver wound of head

Suicidal

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Paul L. Case, M. D.

5-18-29, 19 (Address) Coroner Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Kohlerlawn cemetery	

20. Undertaker	Address
~~Paul L. Case~~ Wm D Dalley	~~Caldwell Idaho~~ Nampa Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66192

PLACE OF DEATH
County of Canyon
City of

Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 65
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Esther A Cobb

(a) Residence. No. 14 South of Ramp 9 St. 74a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 23-1851

7. AGE — Years: 77 | Months: 7 | Days: 22 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS

10. NAME OF FATHER: John Shaffner
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: B. E. Cobb
(Address) R 2 & 3, Boise Idaho

15. Filed May 20, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 3, 1929
that I last saw h[illegible] alive on May 3, 1929
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Haemorrhage in Brain
(duration) yrs. mos. 12 ds.
CONTRIBUTORY (Secondary) Had two strokes previous, Partial paralysis (duration) about 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace B Belknap, M. D.
5/16, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Boise Idaho — Date of Burial: May 18 1929
20. Undertaker: Summers & Reed — Address: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66193

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

2. FULL NAME James Moore 44
(a) Residence. No. Soda Springs Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Moore.

6. DATE OF BIRTH (month, day and year) Dec 18-1863

7. AGE Years 66 Months 5 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Willard Utah

PARENTS
10. NAME OF FATHER H. L. Moore
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Slack
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Emma Moore
(Address) Soda Springs Ida

15. Filed 5-26, 1929 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to May 25, 1929
that I last saw her alive on May 24, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) 0

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? 0 Date of .....
Was there an autopsy? 0
What test confirmed diagnosis? Physical Examination
(Signed) Eric Kaneley, M. D.
5-26-, 1929 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Idaho — Date of Burial 5-28-1929

20. Undertaker G. L. Whiteman — Address Soda Springs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1929

PLACE OF DEATH

County of Cassia

City of Burley

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66194

Registration District No. 37

Primary Registration District No. 2085

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chester James Rydalch

1016

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
57	1	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Farm work

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: William M. Rydalch

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Hunter

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: J. M. Rydalch
(Address) Burley Ida.

15. Filed 6-10, 1929 H N Leeds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26, 1929, to May 31, 1929

that I last saw his alive on May 30, 1929

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Nephritis

Several (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Geo Schultz, M. D.

May 31, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Oakley Ida ~~Twin Falls Ida~~ | Date of Burial: June 3 1929

20. Undertaker: White Mortuary | Address: Twin Falls Ida

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66195

PLACE OF DEATH
County of Clearwater
City of Weippe

Registration District No. 90
Primary Registration District No. 2187
(No. 118)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 60

2. FULL NAME Richard Lowell Snyder

(a) Residence. No. ... St. ...
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 29, 1919

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	9	7	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Wenatchee Wash.

PARENTS

10. NAME OF FATHER Sterling Snyder
11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Va.
12. MAIDEN NAME OF MOTHER Carrie Oressa Brubaker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant ~~Re~~ Sterling Snyder
(Address) Weippe

15. Filed 6-27, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 25th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16th, 1929, to May 20th, 1929
that I last saw him alive on May 20th, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Flue - Pneumonia -

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) W. H. Johnson M. D.
5-27, 1929 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Weippe Ida	6/27 1929
20. Undertaker W. L. Pinson	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66196

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 61
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hans K. Helbostad

(a) Residence. No. 88 St. Wallace, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 9 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 27. 1858

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	71	1	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Unascertained
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed 6/29, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to May 24, 1929
that I last saw him alive on May 24, 1929
and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease
(mitral regurgitation).
(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Epileptic psychosis
epileptic deterioration (duration) 10 yrs. 8 mos. ds.

18. Where was disease contracted ✓ if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs

(Signed) John Irvine McKelvey, M. D.
May 24, 1929 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cemetery, No. Ida. Sanitarium	May 27 1929
20. Undertaker	Address
F. A. Billberg. Hosp. attat.	Orofino - Idaho

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66197

PLACE OF DEATH

County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 59

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Wendell

(a) Residence. No. ..... St. 88
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 60 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Wood Worker
(b) General nature of industry, business, or establishment in which employed (or employer): not employed
(c) Name of employer: X

9. BIRTHPLACE (city or town) (State or country): not Known

PARENTS

10. NAME OF FATHER: not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ✓
12. MAIDEN NAME OF MOTHER: not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ✓

14. Informant: Orofino Hospital
(Address): Orofino Ida

15. Filed 5/22, 1929. W. A. Shaw, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec., 1928, to May 20, 1929
that I last saw him alive on May 20, 1929
and that death occurred, on the date stated above, at 9:00 P.m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical and laboratory.
(Signed) O M Husted, M. D.
May 21, 1929 (Address) Orofino, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Weiffer Ida
Date of Burial: 5/23 1929

20. Undertaker: W. D. Pinson
Address: Orofino Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66198

PLACE OF DEATH
County of Clearwater
City of Cavendish

Registration District No. 90
Primary Registration District No. 2157
(No.)
Local Registrar's No. 58

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Francis Davis

(a) Residence. No. 84 St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Cora Burnetta Davis

6. DATE OF BIRTH (month, day and year) Nov 13. 1885

7. AGE	Years	Months	Days	If LESS than 1 day,
	43	5	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Claude Huffman

9. BIRTHPLACE (city or town) (State or country) Nebr.

PARENTS

10. NAME OF FATHER Flando Corty Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) —
12. MAIDEN NAME OF MOTHER Ellen Martha Porter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Cora B. Davis
(Address) Cavendish Ida

15. Filed 6/5, 1929. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 6, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1928, 19 to , 19
that I last saw him alive on May 6, 1929. , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Internal injuries due to an accident (crushed by a log) at a sawmill. Died in a few hours. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Oliver J. Morehead M. D.
May 6, 1929 (Address) Kendrick, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cavendish Ida	May 8 19
20. Undertaker W. D. Pinson	Address Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66199

PLACE OF DEATH
County of Custer
City of Challis

Registration District No. 108
Primary Registration District No. 2186
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 89

2. FULL NAME Margaret Centaurus

(a) Residence. No. Challis, Idaho St. X
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

886

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Centaurus

6. DATE OF BIRTH (month, day and year) March 28, 1855

7. AGE 74 Years | 1 Months | 3 Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hamburg, Germany

PARENTS
10. NAME OF FATHER Wm. Meyers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant William Centaurus
(Address) Challis Idaho

15. Filed May 2, 1929 Edna McKenney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1st (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/24, 1929, to May 1st, 1929
that I last saw her alive on May 1st, 1929
and that death occurred, on the date stated above, at 11 a. m.
The CAUSE OF DEATH* was as follows:

Myocarditis and Broncho pneumonia
Pneumonia (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? NO Date of .....
Was there an autopsy? NO
What test confirmed diagnosis? NO
(Signed) C. L. Kirtley, M. D.
5/2, 1929 (Address) Challis, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonanza, Idaho | Date of Burial: May 3 1929

20. Undertaker: Theo. P. Garnier | Address: Mackay, Ida.

RECEIVED MAY 16 1929

FORM V. S. No. 5-25 M. 1-16-19

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Custer — Registration District No. 76

City of Mackay — Primary Registration District No. 2153

(No. ....., ... St.)

File No. 66200

Registered No. 111

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel Mae Blume

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 2 (Day) 1900 (Year)

7. AGE: 28 Yrs. 4 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): H Wife

9. BIRTHPLACE (State or Country): N. M.

10. NAME OF FATHER: W. H. McLaughlin

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Sara Ann Gray

13. BIRTHPLACE OF MOTHER (State or Country): Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Burch.

(Address) Mackay, Idaho

15. Filed May 11 1929 Rose Novak Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/13/29 191..., to 4/24/29 191..., that I last saw h[er] alive on 4/24/29 191..., and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia (miscarriage)

(Duration) — Yrs. — mos. 7 ds.

Contributory (Secondary) Pulmonary Abcess (Septic)

(Duration — yrs. — mos. 5 ds.

(Signed) F. P. Richards M. D.

4/25 1929 (Address) Mackay - Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Challis - Ida | DATE OF BURIAL: May 26 1929

20. UNDERTAKER: Shea R. Garnier | ADDRESS: Mackay Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24853

RECEIVED MAY 1 1929

FORM V. S. No. 5-25 M. 1-16

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

66201

1. PLACE OF DEATH.

County of Custer

City of Mackay

Registration District No. 16

Primary Registration District No. 2153

(No. ..... St.)

File No. .....

Registered No. 110

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Hosford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
M	Wh	Widowed

6. DATE OF BIRTH. July (Month) 13 (Day) 1853 (Year)

7. AGE ..... Yrs. 75 Mos. 9 ds. 11

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Wm Hosford

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER Katherine Mowen

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. H Hosford

(Address) Mackay Idaho

15. Filed May 11 1929 R. S. Munroe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/10/29 191..., to 2/22/29 191..., that I last saw him alive on 4/24/29 191..., and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary) Chronic Myocarditis

(Duration 1 yrs. — mos. — ds.

(Signed) F. A Richards M. D.

4/25/29 (Address) Mackay Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Challis Ida. | DATE OF BURIAL 4/27 1929

20. UNDERTAKER Theo. R. Garmire | ADDRESS Mackay Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66202

PLACE OF DEATH

County of Custer
City of Mackay
Registration District No. 16
Primary Registration District No. 2153
(No.)
Local Registrar's No. 109

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mrs Julia Ferguson

(a) Residence. No. Barton-on ranch St. 129
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Reuben C. Ferguson

6 DATE OF BIRTH (month, day and year) July 22 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	75	10	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ranch woman
(b) General nature of industry, business, or establishment in which employed (or employer) x
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS
10 NAME OF FATHER David Newton
11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania
12 MAIDEN NAME OF MOTHER Ann Wells
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Chas Thomas
(Address) Mackay Idaho

15 Filed May 11, 1929 Rose Novack
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4 (Month) 24 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 4/7/29, 1929, to 4/24, 1929, that I last saw her alive on 4/24, 1929, and that death occurred, on the date stated above, at 4 PM m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C A Peterson, M. D.

, 19 (Address) Mackay Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Mt. View Cem. Mackay Ida.	
20. Undertaker Geo. R. Garnier	Address Mackay, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66203

PLACE OF DEATH
County of Custer
City of Mackay
Registration District No. 7e
Primary Registration District No. 2153
(No. George R. Morgan's home)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 108

2. FULL NAME James Elsmere Savaria

(a) Residence. No. Moore, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 8 - 1907

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	1	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) mining.
(c) Name of employer Mackay Metals Co.

9. BIRTHPLACE (city or town) Moore
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Ulysses Milton Savaria
11. BIRTHPLACE OF FATHER (city or town) Eau Claire
(State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Lillian May Fry
13. BIRTHPLACE OF MOTHER (city or town) Decatur
(State or Country) Iowa

14. Informant Lillian M. Savaria
(Address) Moore, Idaho, R.F.D. #1

15. Filed May 11, 1929 Rose Nevins
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-8, 1929, to 3-30, 1929
that I last saw him alive on 3-30, 1929
and that death occurred, on the date stated above, at 10 45 P m.

THE CAUSE OF DEATH* was as follows:
Bronchopneumonia
(Duration)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Conrad A Johnson, M. D.
, 19 (Address) Mackay Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moore	Apr. 1 1929
20. Undertaker	Address
Theo R. Garmin	Mackay Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66204

PLACE OF DEATH
County of Custer
City of Mackay

Registration District No. 16
Primary Registration District No. 2153
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 107

2. FULL NAME Jacob William Thomas

(a) Residence. No. Mackay, Idaho St. 74a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE wt
5. Single, Married, Widowed, or Divorced (write the word) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X
6. DATE OF BIRTH (month, day and year) unknown
7. AGE Years 67 Months Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Machine worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer unemployed
9. BIRTHPLACE (city or town) (State or country) Cardiff, Wales

PARENTS
10. NAME OF FATHER Thomas Thomas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Ann ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales.

14. Informant Mrs J R Ponce
(Address) Mackay - Ida

15. Filed May 11, 1929 Rose Nowack Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) — 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-13, 1929, to 2-13, 1929
that I last saw him alive on 2/13 29, 19
and that death occurred, on the date stated above, at 3 40 a m.
The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C E Jensen M. D.
, 19 (Address) Mackay Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt. McCabe Cemetery | Date of Burial 19
20. Undertaker Geo. R. Garner Mackay Ida | Address

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66205

PLACE OF DEATH
County of Custer
City of Mackay

Registration District No. 16
Primary Registration District No. 2153
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 106

2. FULL NAME Olive Margaret Jensen Petersen

179

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: wt
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Eugene Petersen

6. DATE OF BIRTH (month, day and year) Jan. 27, 1904

7. AGE: Years 24 | Months x | Days x | If LESS than 1 day, ... hrs. or x min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Park City, Utah

PARENTS

10. NAME OF FATHER Julius Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holiday, Utah
12. MAIDEN NAME OF MOTHER Levin Wilkerson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Eugene Petersen
(Address) Mackay, Ida

15. Filed May 11, 1929. Rose Nowacki
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-16, 1929, to 1-27, 1929
that I last saw her alive on ....., 19....
and that death occurred, on the date stated above, at 1.45 p. m.
The CAUSE OF DEATH* was as follows:
(Accidental)
Burns following
Kerosene Explosion
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) C. A. B. Jensen, M. D.
1/28, 1929 (Address) Mackay, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salt Lake City
Date of Burial: Jan. 31 1929

20. Undertaker: Theo. R. Garner
Address: Mackay

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66206

PLACE OF DEATH

County of Elmore
City of Glenns Ferry
Registration District No. 36
Primary Registration District No. 2021
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Mc Donald

(a) Residence. No. Glenns Ferry Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6. DATE OF BIRTH (month, day and year) Feb 2 - 1849

7. AGE Years	Months	Days	If LESS than 1 day,
80	3	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Janitor St Bridgets Hall
(b) General nature of industry, business, or establishment in which employed (or employer) Janitor Work
(c) Name of employer St Bridgets Society

9. BIRTHPLACE (city or town) Kilmarnock
(State or country) Ayrshire Scotland

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14. Informant Jno. Campbell
(Address) Glenns Ferry Idaho

15. Filed May 6, 1929 Mrs Mary L Sullivan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27, 1929, to May 3, 1929
that I last saw him alive on May 2nd 1929
and that death occurred, on the date stated above, at 7.15 a.m.
The CAUSE OF DEATH* was as follows:
Hemorrhage of the perforating
(duration) 2 yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. W. Davis M. D.
May 3rd, 1929 (Address) Glenns Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Glenns Ferry Idaho	May 6th 1929
20. Undertaker	Address
G. C. Zucker	Mountain Home Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1929

PLACE OF DEATH

County of Franklin

City of Clifton

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 66207

Local Registrar's No.

2. FULL NAME Mona Hooker Johnson

(a) Residence. No. 101 St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 2 1929

7. AGE — Years | Months | Days: 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Clifton Idaho

PARENTS

10. NAME OF FATHER: Laurence B. Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ogden Utah

12. MAIDEN NAME OF MOTHER: Lucy Hooker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Clifton Idaho

14. Informant: Laurence Johnson
(Address): Clifton Idaho

15. Filed May 28, 1929. C. P. Wells Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23, 1929, to May 24, 1929, that I last saw h[illegible] alive on May 24, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Wolley M. D.

May, 1929 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clifton Idaho | Date of Burial: May 26 19

20. Undertaker: M. W. Hendricks | Address

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 6 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

66208

1. PLACE OF DEATH
County of Franklin
City of Preston, Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St.)

State File No.
Local Registrar's No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ulean Way

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: May (Month) 11 (Day) 1929 (Year)

7. AGE: ___ Yrs. ___ Mos. ___ ds.
IF LESS than 1 day how many ___ hrs. or few min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer): ✓

9. BIRTHPLACE (State or Country): Preston, Ida

10. NAME OF Father: Ross C. Way

11. BIRTHPLACE OF FATHER (State or Country): Doodle, Utt

12. MAIDEN NAME OF MOTHER: Iris Harris

13. BIRTHPLACE OF MOTHER (State or Country): Fairview, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ross C. Way
(Address): Preston, Ida

15.
Filed 19
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 — 1929. to May 12 1929, that I last saw him alive on May 12 1929, and that death occurred on the date stated above, at 12 29 a M.

The CAUSE OF DEATH* was as follows:
Premature birth.

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory (Secondary) Birth at 6½ months
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Guy W. Stutes M. D.
5/12 1929 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview, Ida
DATE OF BURIAL: May 12 1929

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 6 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

66209

1. PLACE OF DEATH

County of Franklin

City of Preston, Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St.)

State File No.

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gean Day

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word)

6. DATE OF BIRTH: May (Month) 11 (Day) 1929 (Year)

7. AGE: — Yrs. — Mos. — ds.

IF LESS than 1 day how many hrs. or few min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Preston, Ida

10. NAME OF Father Ross C. Day

11. BIRTHPLACE OF FATHER (State or Country) Zooele, Ut

12. MAIDEN NAME OF MOTHER Iris Harris

13. BIRTHPLACE OF MOTHER (State or Country) Fairview, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ross C. Day

(Address) Preston, Ida

15. Filed 19 A. R. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

161a

16. DATE OF DEATH: May (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1929, to May 11 1929, that I last saw her alive on May 11 1929, and that death occurred on the date stated above, at 11 45 p M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) 6½ mo pregnacy

(Duration) yrs. mos. ds.

(Signed) G. W. States M. D.

5/12 1929 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview, Ida

DATE OF BURIAL: May 12 1929

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66211

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ronald J. Sant

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

101 8

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 19

7. AGE Years Months 1 Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED baby

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Treasureton Idaho

PARENTS

10. NAME OF FATHER Geo Ralph Sant

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Preston Idaho

12. MAIDEN NAME OF MOTHER Georgia Bennett

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Soda Springs

14. Informant Geo R. Sant

(Address) Soda Springs

15. Filed May 26, 1929 G. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1929, 1929, to May 22, 1929 that I last saw him alive on May 22, 1929 and that death occurred, on the date stated above, at 1:30 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. W. States, M. D.

May 23, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Treasureton Idaho — Date of Burial: May 24 19

20. Undertaker: M. W. Hendrickd — Address: Preston, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1929

PLACE OF DEATH

County of Franklin

City of Preston Ada

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66212

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rose England Winn

(a) Residence. No. Winder St. 101a

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of widow

6. DATE OF BIRTH (month, day and year) Oct 9 1873

7. AGE Years 55 Months 7 Days 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Plain City Utah

PARENTS

10. NAME OF FATHER James England

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Rose H Smith

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Herbert Winn

(Address) Preston Ada

15. Filed May 23, 1929 A. R. Oviler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1929, to May 21, 1929 that I last saw her alive on May 21, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Thos B Holder, M. D.

5/22, 1929 (Address) Preston Ada

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston, Ida

Date of Burial: May 25 1929

20. Undertaker: M. W. Hendrick

Address: Preston, Ida

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66213

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Julia Ann Roper

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph B. Roper

6. DATE OF BIRTH (month, day and year) Dec. 25 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	77	4	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lehi Utah
(State or country)

PARENTS

10. NAME OF FATHER Suel Lamb

11. BIRTHPLACE OF FATHER (city or town) New York
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Zimmerman

13. BIRTHPLACE OF MOTHER (city or town) Penn.
(State or Country)

14. Informant Mrs Wm Fellows
(Address) Preston Idaho

15. Filed May 15, 1929 A. R. Quiles Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 10, 1929
that I last saw her alive on May 8, 1929
and that death occurred, on the date stated above, at noon m.
The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) General Arterio Sclerosis

(duration) 20 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) A. R. Quiles, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	May 12 29

20. Undertaker	Address
M. W. Hendricks	Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66214

PLACE OF DEATH

County of Franklin
City of Riverdale
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1016

2. FULL NAME Margie Packer

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 31 1924

7. AGE	Years	Months	Days	If LESS than 1 day,
	4	5	18	hrs. or min.

8. OCCUPATION OF DECEASED Child
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hyrum Utah

PARENTS

10. NAME OF FATHER Oren Packer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Riverdale Idaho
12. MAIDEN NAME OF MOTHER Pearle C. Christensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hydepark Utah

14. Informant Oren Packer
(Address) Riverdale Idaho

15. Filed May 20, 1929 A. R. Curtis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-10, 1929, to 5-15, 1929, that I last saw h[illegible] alive on 5-18, 1929, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) A. R. Curtis Jr. M. D.
5-18, 1929 (Address) Preston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverdale Idaho	May 20 1929

M 20. Undertaker M. W. hendricks — Address Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66215

PLACE OF DEATH
County of Franklin
City of ~~Weston~~ Dayton Ida

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arnold Amueld Naef

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

203

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): marrrid

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Margurett whitehead Naef

6. DATE OF BIRTH (month, day and year): Mar 8 1894

7. AGE: Years 35, Months 2, Days 17. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mapleton Idaho

PARENTS

10. NAME OF FATHER: Ja ob I. Naef
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Switzerland
12. MAIDEN NAME OF MOTHER: Anna C. Tobler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Switzerland

14. Informant: Margurett Naef
(Address): Dayton Idaho

15. Filed May 28, 1929 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to May 25, 1929
that I last saw h— alive on —, 19—
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
This May Killed—
Was dead when brought in at 6 P.M.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. W. States, M. D.
, 19 (Address) Preston, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Franklin Idaho
Date of Burial: May 27 1929

20. Undertaker: M.W.Hendricks
Address: Preston

M. Haney - Coroner.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66216

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Dennis Nelson

(a) Residence. No. St. 162
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) S.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 9 1929

7. AGE Years Months Days If LESS than 1 day, 12 hrs. or min.

8. OCCUPATION OF DECEASED —
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Preston Idaho

PARENTS

10. NAME OF FATHER Lars Willard Nelson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mink Creek Idaho
12. MAIDEN NAME OF MOTHER Iva Bell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Weston Idaho.

14. Informant Lars Willard Nelson
(Address)

15. Filed May 10, 1929. A. R. Oviller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-9, 1929, to 5-9, 1929
that I last saw him alive on 5-9, 1929
and that death occurred, on the date stated above, at 12 30 p m.
The CAUSE OF DEATH* was as follows:
Esophagitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Premature
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. R. Oviller, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mink Creek. Date of Burial: May 10 1929

20. Undertaker: M. W. Hendricks Address: Preston Idaho

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66217

PLACE OF DEATH

County Franklin
City of Preston
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 205 O)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah LeeEsther Smith

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Milton Smith

6. DATE OF BIRTH (month, day and year) may 23 I885

7. AGE	Years	Months	Days	If LESS than 1 day,
	43	II	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minkcreek Idaho

PARENTS

10. NAME OF FATHER Wm. Baird
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Brigham Utah
12. MAIDEN NAME OF MOTHER Charlotte e. Keller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mantua Utah

14. Informant Wm. Baird
(Address) Minkcreek Idaho

15. Filed May 23, 1929 A R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-19, 1929, to 5-21, 1929, that I last saw h[illegible] alive on 5-21, 1929, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows: Surgical shock.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Emphysema.

(duration) yrs. 8 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) A R. Cutler, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Georgetown Idaho	May 23 29
20. Undertaker M. W. Hendricks	Address Preston Id ho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66218

PLACE OF DEATH
County of Franklin
City of Dayton

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Willard J. Jones

(a) Residence. No. St. 162
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 25 29

7. AGE Years Months Days If LESS than 1 day, 3 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dayton Idaho

PARENTS
10. NAME OF FATHER Manon Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dayton Idaho
12. MAIDEN NAME OF MOTHER Elda Jensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ephriam Utah

14. Informant Manon Jones
(Address) Dayton Idaho

15. Filed May 28, 1929 A. R. Curtis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to May 25, 1929
that I last saw him alive on May 25, 1929
and that death occurred, on the date stated above, at 10:30 a.m.
The CAUSE OF DEATH* was as follows:
Congenital heart disease - Blue baby
(duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical
(Signed) G. W. States, M. D.
May 26, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Dayton Idaho
Date of Burial May 26 1929

20. Undertaker
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66219

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Owens

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

91 K

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm J. Owens

6. DATE OF BIRTH (month, day and year) Mar 6 1835

7. AGE	Years	Months	Days	If LESS than 1 day,
	94	2	27	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10. NAME OF FATHER Hugh Roberts

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales

12. MAIDEN NAME OF MOTHER Mary Owens

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant Mrs Mary O.T. Pratt
(Address) Preston, Idaho

15. Filed , 19 G.P. Miles
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-1, 1929, to 6-9, 1929, that I last saw her alive on 5-15, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Asthenia collapse
Ch. Dr. interstitial
Nephritis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) 1 yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G.P. Miles M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial

Smithfield Utah | June 6 1929

20. Undertaker | Address

M.W. Hendricks | Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66220

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No. 6
Primary Registration District No.
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Caroline Barlow Westberg 41

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 10 - 1894

7. AGE — Years 35 | Months 3 | Days 6 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Peter Barlow
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Carl A. Westberg
(Address) Emmett Ida

15. Filed 5/18, 1929 J. K. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 16, 1929
that I last saw her alive on May 16, 1929
and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:
Septicaemia following tonsilitis

(duration) yrs. mos. 18 ds.
CONTRIBUTORY (Secondary) Lobar pneumonia
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no specific test

(Signed) L. R. Cummings, M. D.
5/18, 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 5/19 1929
20. Undertaker: E. W. Bucknum — Address: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66221

PLACE OF DEATH
County of Ada
City of Emmett
Registration District No. 6
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Wesley Ramson
(a) Residence No. St. 128
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept 12-1914

7. AGE: Years 14 | Months 8 | Days 7 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ogden Utah

PARENTS

10. NAME OF FATHER: Karl Ramson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Nellie Robbins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: J. W. Myles.
(Address) Emmett Idaho

15. Filed 5/21, 1929 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Summer, 1928, to May 18, 1929
that I last saw him alive on May 18, 1929
and that death occurred, on the date stated above, at 10 9 m.
The CAUSE OF DEATH* was as follows:
Chronic cystitis nephritis
following measles

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) measles
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) R. N. Cummins M. D.
5/22, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Ida — Date of Burial: 5/22 1929
20. Undertaker: O D Bucknum — Address: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-15 RECEIVED JUN 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 06222
Registered No. 98

1. PLACE OF DEATH
County of Gooding
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. Canfield
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word): Married

6. DATE OF BIRTH: April (Month) 5 (Day) 1866 (Year)

7. AGE: 63 Yrs. 1 Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Hiram Canfield

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER: Mary J McCarty

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Chas Canfield
(Address) Gooding Ida.

15. Filed 5/31 1929 J H Cranmer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-1- 1929, to 5-14- 1929 that I last saw h~~e~~ alive on 5-14- 1929 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Chronic heart disease
(Mitral insufficiency)
(Duration) ? Yrs. mos. ds.
Contributory (Secondary) Dropsy
(Duration) yrs. 6 mos. ds.

(Signed) J H Cranmer M. D.
5/16 1929 (Address) Gooding

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding - Idaho
DATE OF BURIAL: 5-16- 1929

20. UNDERTAKER: A C Thompson
ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. RECEIVED JUN 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24

Primary Registration District No.

(No. , St.)

File No. 66224

Registered No. 96

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas. Robt. Hulbert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb 12 1920 (Month) (Day) (Year)

7. AGE: 9 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Gooding Ida

10. NAME OF FATHER: Chas. Hulbert

11. BIRTHPLACE OF FATHER (State or Country): Nebr.

12. MAIDEN NAME OF MOTHER: Helen Stimpson

13. BIRTHPLACE OF MOTHER (State or Country): Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Hulbert

(Address) Gooding Ida

15. Filed 5/31 1929 J H Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

204

16. DATE OF DEATH: May 28 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-15 1929, to 5-28 1929 that I last saw him alive on 5-25 1929, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Sudden death = Cause unknown probably epileptic convulsion

(Duration) Yrs. mos. ds.

Contributory (Secondary) Idiocy

(Duration) 9 yrs. 3 mos. 15 ds.

(Signed) J H Cromwell M. D.

19 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida

DATE OF BURIAL: 5/29 1929

20. UNDERTAKER: A. E. Thompson

ADDRESS: Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. RECEIVED JUN 6 1929 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Gooding
City of [illegible]
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24
Primary Registration District No.
(No. , St.)

File No. 15826
Registered No. 94

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel Martin Graham

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 22 (Day) 1849 (Year)

7. AGE: 79 Yrs. 9 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn,

10. NAME OF FATHER: Wm Graham

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Eliza Dixon

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs L Graham
(Address): Gooding Ida

15. Filed 5/16 1929 J H Cromwell, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-1- 1929, to 5-15- 1929 that I last saw h[illegible] alive on 5-15- 1929, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Brights disease

(Duration) ? Yrs. ? mos. ? ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Cromwell M. D.
5/16 1929 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida
DATE OF BURIAL: 5/17 1929

20. UNDERTAKER: A C Thompson
ADDRESS: Goodings Ida

FORM V. S. No. 5-25 M. 1-[illegible] RECEIVED JUN 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24

Primary Registration District No.

File No. 05228

Registered No. 92

1. PLACE OF DEATH

County of Gooding

City of "

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Bradshaw Bishop

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Feb. (Month) 20th (Day) 1839 (Year)

7. AGE: 90 Yrs. 2 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: John Bishop

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Lucinda [illegible] Bearow

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A. B. Slater
(Address) Gooding Ida

15. Filed 5/31 1929 — J H Cromwell, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20 1929, to May 4 1929 that I last saw her alive on May 1 1929 and that death occurred on the date stated above, at 6 30 A M.

The CAUSE OF DEATH* was as follows:
Uremia — Chronic nephritis
Chronic heart disease

(Duration) Yrs. mos. 30 ds.

Contributory (Secondary): prostatic hypertrophy

(Duration) ? yrs. mos. ds.

(Signed) J H Cromwell M. D.

5/5 1929 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Gooding Ida — DATE OF BURIAL: 5/6 1929

20. UNDERTAKER: A. E. Thompson — ADDRESS: Gooding Ida.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66229

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 26
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JUN 3 1929

2. FULL NAME Adelia Jeffries

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of W of T. Jeffries
6. DATE OF BIRTH (month, day and year)
7. AGE Years 72 Months 2 Days 6 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work H W
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Pa

PARENTS
10. NAME OF FATHER Bogard
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Ann Henderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Nellie E. Gelbach
(Address) 1703 Ruby St Pullman Wash
15. Filed 6-1-, 1929. B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 14 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1928, to Jan 14, 1929
that I last saw her alive on Jan 13, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Pneumonia a following influenza
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical course
(Signed) Wesley F. Orr, M. D.
Jan 14, 1929 (Address) Cottonwood

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida.	1-16- 1929
20. Undertaker	Address
Henderson Mod. Co.	Grangeville Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66230

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 25

RECEIVED JUN 3 1929

2. FULL NAME Thomas H Jeffries

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs A Jeffries

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 86 | Months | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: R
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bay C Mo

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Robison
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Nellie E. Gelbach
(Address) 1703 Ruby St Pullman Wash

15. Filed 6-1-, 1929. B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1929, to Jan 11, 1929
that I last saw him alive on Jan 11, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Pneumonia
..... (duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Influenza and Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical Course
(Signed) Wesley F. Orr, M. D.
Jan 11, 1929 (Address) Cottonwood Ida,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grangeville Ida, | Date of Burial: 1-12-1929

20. Undertaker: ~~Kessler~~ Hancock Mel Co. | Address: Grangeville Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66232

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No. At home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

RECEIVED JUN 3 1929

2. FULL NAME Mark L. Derrig

(a) Residence. No. Grangeville St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nora Derrig

6. DATE OF BIRTH (month, day and year) Nov. 13. 1870

7. AGE Years 53 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Paul Minn

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Raymond Derrig
(Address) Grangeville Ida

15. Filed 6-1-, 1929 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9, 1929, to March 16, 1929
that I last saw him alive on March 16 1929
and that death occurred, on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Signs
(Signed) J. D. Shiannick M. D.
3/16, 1929 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville Idaho
Date of Burial 3/2 1929

20. Undertaker Vassar Mortuary
Address Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66233

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No.
Primary Registration District No.
(No. Grangeville Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22

74 a

RECEIVED JUN 8 1929

2. FULL NAME Emma Myrtle Gillett

(a) Residence. No. 4 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. ~~Single~~, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Gillett

6. DATE OF BIRTH (month, day and year) Aug 4 1869

7. AGE Years 59 Months 5 Days 26 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS
10. NAME OF FATHER W H Crites
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER Peobe Saxton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant Frank Gillett
(Address) Lewiston Idaho.

15. Filed 6-1-, 1929 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1929 to Jan 30, 1929
that I last saw her alive on Jan 30, 1929
and that death occurred, on the date stated above, at 8 a m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J F Weber, M. D.
Jan 30, 1929 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville Idaho Date of Burial Feb 2 1929

20. Undertaker Vassar's Address Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66234

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 21

100a

RECEIVED JUN 3 1929

2. FULL NAME Ona Eugenie Undeen
(a) Residence. No. 119 South 3rd St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Caucasian
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ruben John Undeen

6. DATE OF BIRTH (month, day and year)

7. AGE: 47 Years | Months: 9 | Days: 16 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Decatur, Arkansas

PARENTS
10. NAME OF FATHER: Allen D. Hall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....
12. MAIDEN NAME OF MOTHER: Francis Simpson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant: Virgie Undeen
(Address) 119 South 3rd St. Grangeville

15. Filed 6-1-, 1929. B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31, 1929, to April 2, 1929
that I last saw her alive on April 1, 1929
and that death occurred, on the date stated above, at 2 45 a.m.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) J. L. Weber, M. D.
May 2, 1929 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grangeville Idaho | Date of Burial: 3/3 1929

20. Undertaker: Brower-Warren Co | Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66235

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184

Local Registrar's No. 174

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Roselma Kipp

163

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): June 16-1928

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kooskia - Idaho

PARENTS

10. NAME OF FATHER: Joseph Kipp
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Esther Lott
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Esther Lott
(Address)

15. Filed April 25, 19 29 J M Kerbekmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH* was as follows:
No medical attendant.
Baby found dead in bed.
in morning.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J M Kerbekmore, M. D.
April 25, 1929 (Address) Kooskia Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pruett Cemetery — Date of Burial: April 24 1929
20. Undertaker — Address

RECEIVED MAY 19 1929

FORM V. S. NO. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65236

Registration District No. 106

Primary Registration District No. 2184

(No. ..... St.)

Local Registrar's No. 272

1. PLACE OF DEATH
County of Idaho
City of Kooskia
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas August Fitting

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: April (Month) 26 (Day) 1878 (Year)

7. AGE: 50 Yrs. 11 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Dakota

10. NAME OF Father: August Fitting

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Mary A. Gilroy

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) August T. Fitting
(Address) Kooskia - Idaho

15. Filed April 11 1929 J. M. Verbeke
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5 1929 to April 9 1929
that I last saw him alive on April 9 1929
and that death occurred on the date stated above, at 5:10 P.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) C. Chronic Int. Nephritis,
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Verbeke M. D.
19 ..... (Address) Kooskia - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kooskia Cemetery
DATE OF BURIAL: April 12 1929

20. UNDERTAKER: Geo Freeman
ADDRESS: Kooskia

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66237

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2,184
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 273

2. FULL NAME Marie K. Clements

162

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) April 11 - 1929

7. AGE Years | Months | Days | If LESS than 1 day, 10 hrs. or 1 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant -
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kooskia - Idaho

PARENTS

10. NAME OF FATHER Homer J. Clements
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sun City - Kan
12. MAIDEN NAME OF MOTHER Amy Kyle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Homer J. Clements
(Address) Kooskia

15. Filed April 13, 1929 J M Verberkmoes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:
No medical attendant.
Hemorrhage from mouth and rectum, which began shortly after birth. (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J. M. Verberkmoes, M. D.
April 13, 1929 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bahor Cemetery | Date of Burial April 13 1929

20. Undertaker | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-A RECEIVED JUN 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Cottonwood

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105

Primary Registration District No. 2183

(No. ..... , ... St.)

File No. 66238

Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Krieger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: May (Month) 8 (Day) 1845 (Year)

7. AGE: 84 Yrs. ..... Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Bernard Beste

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ben Krieger

(Address) Kenterville Idaho

15. Filed May 31 1929 W. F. Orr per J.B. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1929, to May 27 1929, that I last saw her alive on 26 19..., and that death occurred on the date stated above, at 11:20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wesley Orr M. D.

5/28 1929 (Address) Cottonwood Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Kenterville Idaho

19. PLACE OF BURIAL OR REMOVAL: Kenterville Ida. DATE OF BURIAL: May 31 1929

20. ~~UNDERTAKER~~ Ben Krieger ADDRESS: Kenterville Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. RECEIVED JUN 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 8855
Registered No. 7

1. PLACE OF DEATH
County of Idaho
City of Cottonwood Ida. (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Welch
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single. (Write the word.)

6. DATE OF BIRTH: July Unknown 1844 (Month) (Day) (Year)

7. AGE: 85 Yrs. 10 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Michael Welch.

11. BIRTHPLACE OF FATHER (State or Country): Alsace Lorraine

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank G. Linxoll
(Address) Green Creek Ida.

15. Filed May 31 1929 N. F. Orr L.R.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19..., to — 19..., that I last saw h— alive on — 19..., and that death occurred on the date stated above, at — M.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(Duration) 7 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Nephritis
(Duration) Unknown yrs. ..... mos. ..... ds.
(Signed) Perley Orr M. D.
5/19 1929 (Address) Cottonwood Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Green Creek Ida. DATE OF BURIAL: 5/21 1929

20. UNDERTAKER: A. Nau ADDRESS: Cottonwood

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66240

PLACE OF DEATH
County of Idaho
City of Cottonwood

Registration District No. 105
Primary Registration District No. 2183
(No. Cottonwood Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

12/138

2. FULL NAME Parthena Robinson

(a) Residence. No. White bird St. Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sam Robinson

6. DATE OF BIRTH (month, day and year) Nov 23 1891

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	5	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colorado

PARENTS

10. NAME OF FATHER E. B. Wilson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Martha Boythwell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant E. B. Wilson
(Address) Oregon

15. Filed May 31, 1929 N. F. Orr D.R. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1929, to May 10, 1929
that I last saw her alive on May 8 10, 1929
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Acute Influenzitis
(duration) yrs. mos. 12 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of May 6-29
Was there an autopsy? No
What test confirmed diagnosis? Clinical Symptoms
(Signed) Wesley Dow, M. D.
May 11, 1929 (Address) Cottonwood

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Whitebird	5/11 1929
20. Undertaker	Address
Vassar Und Co S. W. Vilor manager	Whitebird

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66241

PLACE OF DEATH
County of Idaho
City of Cottonwood

Registration District No. 105
Primary Registration District No. 2183
Local Registrar's No. 5
(No. At home, Cottonwood)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph James Blackburn

(a) Residence No. Cottonwood, Idaho St. 49
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Blackburn

6. DATE OF BIRTH (month, day and year) April 2 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	1	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10. NAME OF FATHER Joseph Blackburn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina
12. MAIDEN NAME OF MOTHER Rhoda Outz
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14. Informant Eva Blackburn
(Address) Cottonwood Ida

15. Filed May 31, 1929 W. F. Orr D.R. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to May 7, 1929
that I last saw him alive on May 7, 1929
and that death occurred, on the date stated above, at 11 6 m.
The CAUSE OF DEATH* was as follows: Coronary Thrombosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) 1

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. B. Skinner, M. D.
May 9, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cottonwood, Ida	5/13 1929
20. Undertaker	Address
Vassar Und. Co. H. W. Oliver manager	Cottonwood

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66242

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2176
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 31

2. FULL NAME Frank W. Hogue

(a) Residence. No. Rigby St. Idaho
(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 27.

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	9	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Thomas B Hogue
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Mary A Potter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pennsylvania

14. Informant A. J. Hogue
(Address) Rigby Idaho

15. Filed 4-1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on , 19
and that death occurred, on the date stated above, at 4.35 P m.
The CAUSE OF DEATH* was as follows:

Paralysis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Paul F Price M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida.	4/26. 1929
(20. Undertaker) W. F. McHan.	Address Idaho Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66243

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2186

Local Registrar's No. 30

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margery Clegg.

(a) Residence. No. .... St. Heyburn, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Child.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 21, 1923

7. AGE	Years	Months	Days	If LESS than 1 day,
	5	11	0	....hrs. or ....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rigby, Idaho.

PARENTS

10. NAME OF FATHER L. F. Clegg

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Heber City, Utah.

12. MAIDEN NAME OF MOTHER S. R. Campbell.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kaysville, Utah.

14. Informant Mr. L. F. Clegg.
(Address) Heyburn, Idaho.

15. Filed 4-1, 1929 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April, 21, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21, 1929, to ...., 19....
that I last saw h[illegible] alive on ...., 19....
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows:
Pneumonia.

....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) W. R. Hunt, M. D.
April 21, 1929 (Address) Rigby, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Milo Ward, Idaho	4/23/29 19

20. Undertaker [illegible] Address Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66244

PLACE OF DEATH
County of Jerome
City of Jerome
Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma M. Goodrich

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Rufus Goodrich

6. DATE OF BIRTH (month, day and year): Oct 17-1850

7. AGE: Years 78 | Months 6 | Days 28 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kentucky

PARENTS

10. NAME OF FATHER: Marcus Beach

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Cornelia LeHunter

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): France

14. Informant: Miss Mildid Goodrich
(Address): Twin Falls. Idaho

15. Filed 6-15-29 H. N. Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1916, to May 6, 1929
that I last saw h-- alive on May 6, 1929
and that death occurred, on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows: Chronic valvular heart disease mitral and tricuspid

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NV Date of
Was there an autopsy? NV
What test confirmed diagnosis?

(Signed) H W Goodrich M. D.
May 15, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery — Date of Burial: May 17 1929

20. Undertaker: White Mortuary — Address: Twin Falls

RECEIVED MAY 30 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66247

Local Registrar's No. 2-1929

PLACE OF DEATH

County of Kootenai
City of 2 miles E. Harrison
Harrison Flats
Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elva Lelia Procopio

(a) Residence. No. 101 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

6a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Dominic Procopio

6. DATE OF BIRTH (month, day and year) Sept. 15 1886

7. AGE	Years	Months	Days	If LESS than 1 day,
	42	4	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kendrick (State or country) Idaho

PARENTS

10. NAME OF FATHER John Roberts
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Louisa Hill
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Anna Procopio
(Address) Harrison Flats

15. Filed 1-20-, 1929 H.R. Bankard
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30-, 1928, to 1-19-, 1929
that I last saw her alive on 1-18-29, 19
and that death occurred, on the date stated above, at 5:45 P m.
The CAUSE OF DEATH* was as follows: Pneumonia

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Spanish Influenza
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H.R. Bankard M. D.
1-20, 1929 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wash	19
20. Undertaker	Address
O'Leary's	St Maries Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 30 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66248

Local Registrar's No. 1—1929

PLACE OF DEATH

County of Kootenai

City of Harrison

Registration District No. 12

Primary Registration District No. 2304

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucrezia Antonia Procopio

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Caucasian	Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Luigi Procopio

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49	11	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10. NAME OF FATHER Pietro Mozza

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy

12. MAIDEN NAME OF MOTHER Maria Teresa Bettinato

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant Teresa Procopio

(Address) Harrison, Idaho

15. Filed 1-19-, 1929 H.R. Bankard. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 18 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1928, to Jan. 18, 1929 that I last saw ~~has~~ alive on Jan. 18, 1929 and that death occurred, on the date stated above, at 10:10 P m.

The CAUSE OF DEATH* was as follows:

Erysipelas of Face, Scalp + Throat.

..... (duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary)

Spanish Influenza (duration) ..... yrs. ..... mos. 19 ds.

18. Where was disease contracted if not at place of death? L

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) H.R. Bankard, M. D.

1-19, 1929 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrison Cemetery	Jan. 20 1929

20. Undertaker Family. Address Harrison Ida.

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66253

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 66

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma E Morrison

(a) Residence. No. 2 Miles North Atlas St.
(Usual place of abode)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of J. B. Morrison

6. DATE OF BIRTH (month, day and year) July 19 – 18[illegible]

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Frost

11. BIRTHPLACE OF FATHER (city or town) (State or Country) U. S.

12. MAIDEN NAME OF MOTHER [illegible]

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) [illegible]

14. Informant J. B. Morrison
(Address) Coeur d'Alene, Ida. R. D.

15. Filed May 8, 1929. H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2, 1929, to May 6, 1929
that I last saw her alive on May 4, 1929
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:

Apoplexy
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Arterio-sclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. H. Reed, M. D.
5-7, 1929 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	May 10 1929
20. Undertaker	Address
W B Mooney	Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66254

PLACE OF DEATH
County of Kootenai
City of Post Falls

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 67

(No. 128)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martha Gray

(a) Residence. No. Post Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Gray (Deceased)

6. DATE OF BIRTH (month, day and year) Feb 11, 1856

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	2	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Alice Turnbull
(Address) Sagle Idaho

15. Filed May 8, 1929 F. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 28, 1929, to May 1, 1929
that I last saw her alive on Apr 30, 1929
and that death occurred, on the date stated above, at 6 AM m.
The CAUSE OF DEATH* was as follows:

acute Nephritis
(Uremia)
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Symptoms
(Signed) F. L. McCauley, M. D.
May 4, 1929 (Address) Post Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Post Falls, Idaho	May 3 1929

20. Undertaker R. P. Mooney Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1850
File No. 06255
Registered No. 68

1. PLACE OF DEATH
County of Kootenai
City of Worley, Idaho
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alma ~~Isabella~~ Esmarilda Ely.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March 31st 1864 (Month) (Day) (Year)

7. AGE: 65 Yrs. 3 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School - Teacher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Edwin Cody Booz.

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Alma S Miraisty

13. BIRTHPLACE OF MOTHER (State or Country): Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E H Robert
(Address) Worley, Idaho. R 2.

15. Filed May 8 1929 H. J. Stevens Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 3-th 1929. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3rd 1929, to May 3rd 1929, that I last saw h.. alive on May 3rd 1929, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Brights Disease
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Cerebral Hemorrhage.
(Duration) One yrs. ..... mos. ..... ds.

(Signed) J J Herrington M. D.
May 6 1929 (Address) Worley, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Worley, Idaho — DATE OF BURIAL: May 8 1929

20. UNDERTAKER: H. L. Jaeger — ADDRESS: Plummer, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

PLACE OF DEATH

County of Kootenai

City of

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1060

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66256

Local Registrar's No. 69

2. FULL NAME Ellen Jane Steinbaugh

(a) Residence. No. Dalton Gardens St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Steinbaugh

6. DATE OF BIRTH (month, day and year) June 20 1851

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	10	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Ark Ohio

PARENTS

10. NAME OF FATHER William Mapes

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Susan Mapes

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Jacob Steinbaugh

(Address) Coeur d'Alene Ida. R. D.

15. Filed May 9, 1929 H. J. Steinger Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1929, to May 7, 1929

that I last saw h alive on May 7, 1929

and that death occurred, on the date stated above, at 1 PM m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Mooney M. D.

May 8, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood Cemetery	May 11 1929

20. Undertaker R. B. Mooney Address Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66257

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 70

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Francis Holler

(a) Residence No. 316 - Coeur d'Alene St. 1000
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1928-9-2

7. AGE Years 0 Months 8 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Emmadone N.D.

PARENTS

10. NAME OF FATHER Henry Holler

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Brownsville Minn.

12. MAIDEN NAME OF MOTHER Clara Burbank

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Burnt Woods Ore.

14. Informant Henry Holler
(Address) Coeur d'Alene Ida.

15. Filed May 21, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to May 14, 1929
that I last saw him alive on May 14, 1929
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. O. Dawson, M. D.
May 16, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C'd'Alene — Date of Burial 5-16 1929

20. Undertaker Cassedy Funeral Home — Address C'd'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66258

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 71

PLACE OF DEATH
County of Kootenay
City of Coeur d'Alene
(No.) 745
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Geo. K. Evans

(a) Residence. No. 318 6th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widower

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Elizabeth Evans

6. DATE OF BIRTH (month, day and year) 1866-3-10

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	2	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Chief Policeman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lexington Kentucky

PARENTS

10. NAME OF FATHER Wm I. Evans
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Mary Jane Kelly
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Florence Evans Olsen
(Address) 318-6th St

15. Filed May 21, 1929 N. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11, 1929, to May 16, 1929
that I last saw him alive on May 16, 1929
and that death occurred, on the date stated above, at 1120 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Thrombosis
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Chronic myocardial Degeneration
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Paralysis, etc.
(Signed) John Elwood, M. D.
May 18 1929 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C'Alene	5-19 1929
20. Undertaker	Address
Cassedy Funeral Home	C'Alene

REGISTERED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66259

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 72

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arnold L Ostrom

(a) Residence. No. 826 No 2nd St.
(Usual place of abode)
Length of residence in city or town where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 3, 1906

7. AGE	Years	Months	Days	If LESS than 1 day,
	22	6	15	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Duluth
(State or country) Minn

PARENTS

10. NAME OF FATHER Andrew Ostrom

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER Pauline Bjorkman

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Sweden

14. Informant Andrew Ostrom
(Address) Coeur d Alene 21a

15. Filed May 21, 1929 W. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 16th, 1929, to May 18, 1929
that I last saw him alive on May 18, 1929
and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. D. Mayo M. D.
May 21, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	5/21 1929
20. Undertaker	Address
R. B. Mooney	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66260

PLACE OF DEATH
County of Kootenai
City of Coeur D' Alene

Registration District No. 30
Primary Registration District No. 1050
(No. Reed Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 73

1010

2. FULL NAME John H. McFarlin

(a) Residence. No. 1109 11th St.
(Usual place of abode)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jul 20, 1852

7. AGE	Years	Months	Days	If LESS than 1 day,
	76	9	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Chicago Ill.

PARENTS

10. NAME OF FATHER: William W. McFarlin
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Del.
12. MAIDEN NAME OF MOTHER: Mary Garland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N. Y.

14. Informant: Mrs E. M. Jones
(Address): Coeur D' Alene, Ida.

15. Filed May 24, 1929 — F. J. Sturgess, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 20 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to May 20, 1929
that I last saw h.m alive on May 20 1929
and that death occurred, on the date stated above, at 4.30 P. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J. O. Brown, M. D.
May 24, 1929 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Winnetka, Ill.	May 21 1929

20. Undertaker: R B Mooney — Address: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66261

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 74

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

46

2. FULL NAME Archie E. Perry
(a) Residence. No. 1503 Mullan Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 11, 1911

7. AGE Years 17 Months 9 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) West Buro Wisc

PARENTS
10. NAME OF FATHER Frank M. Perry
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Belle Shearer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisc

14. Informant Frank M. Perry
(Address) Coeur d'Alene Ida

15. Filed May 29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1928, to May 27, 1929
that I last saw him alive on May 27, 1929
and that death occurred, on the date stated above at 6:00 p. m.
The CAUSE OF DEATH* was as follows:

Sarcoma of pelvis.
(duration) ..... yrs. 11 mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec 1928
Was there an autopsy?
What test confirmed diagnosis? Laboratory report of excised tissue
(Signed) Alexander Barclay, M. D.
May 29 - 1929 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cemetery
Date of Burial 5/29 1929

20. Undertaker R B Mooney
Address Coeur d'Alene

FORM V. S. No. 5-2 RECEIVED JUN 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 00205

1. PLACE OF DEATH
County of Kootenai
City of Wooley. Idaho.
(No. ..... St.)
Registration District No. 30
Primary Registration District No. 1050.
Registered No. 76
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carrie Asplund.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Nov. 23rd 1858 (Month) (Day) (Year)

7. AGE: 70 Yrs. 6 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden.

10. NAME OF FATHER: Anderson.

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Anderson.

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Clarence Breedlove daughter
(Address) Wooley. Idaho.

15. Filed June 2 1929 H. J. Sturges Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May - 31st 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27th 1929, to May 31st 1929, that I last saw h.. alive on May 31st 9 A.M. 1929, and that death occurred on the date stated above, at 12-30 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of Right Breast
(Duration) 4 Yrs. - mos. - ds.
Contributory (Secondary) General Pulmonary Hemorrhage
(Duration) 4 yrs. - mos. - ds.

(Signed) J. J. Herrington M. D.
May 31 1929 (Address) Wooley. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lone Pine — DATE OF BURIAL: 6/2 1929

20. UNDERTAKER: H. L. Jaeger — ADDRESS: Plummer Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 8 1929

PLACE OF DEATH

County of Kootenai

City of Rathdrum

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

DO NOT WRITE IN THIS SPACE
State File No. 66264

Local Registrar's No. 77

(No. 124)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carrie L. Sanders

(a) Residence. No. R. F. D. 1 St. Rathdrum, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of George W. Sanders

6. DATE OF BIRTH (month, day and year) August 9, 1840

7. AGE	Years	Months	Days	If LESS than 1 day,
	88	9	15	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Near Emporium Penn.

PARENTS

10. NAME OF FATHER Philip Lewis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known

12. MAIDEN NAME OF MOTHER Hannah —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant Claude Sanders
(Address) Rathdrum Idaho

15. Filed June 5, 1929 W. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 24. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1928, to May 24, 1929, that I last saw her alive on May 24, 1929, and that death occurred, on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:
Chronic interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Weng, M. D.

5/25, 1929. (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Brookings S. Dakota	3/30 1927
20. Undertaker	Address
Cassedy Funeral Home	Rathdrum

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66265

PLACE OF DEATH
County of Kootenai
City of Post Falls Idaho

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 78

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William E. Libby

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Minnie E. Libby

6. DATE OF BIRTH (month, day and year) Aug. 30, ~~1865~~ 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	7	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Evansville, Wisconsin

PARENTS

10. NAME OF FATHER William Libby
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Vels Maine
12. MAIDEN NAME OF MOTHER Julia A. Ricker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Somersworth New Hampshire

14. Informant Mary E. Libby
(Address) Post Falls Idaho.

15. Filed June 5, 1929 W. J. Stevens Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 22. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29. 1929, to April 22 1929
that I last saw h— alive on April 22. 1929
and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:
Acute Encephalitis (non-contagious)
(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Frank Stevens M. D.
4/29, 1929 (Address) Rathdrum, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Post Falls, Evergreen Cemetery	4/26 1929
20. Undertaker	**Address**
Farrell Funeral Home	Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66266

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 79

(No. 884)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lydia P. McDuffie

(a) Residence. No. (Usual place of abode) Rathdrum St.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Horace L. McDuffie

6. DATE OF BIRTH (month, day and year) December 24 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	75	3	9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER John Colburn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown - New York?

12. MAIDEN NAME OF MOTHER Charlotte Clemens

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown - New York?

14. Informant H. C. Duffie
(Address) Spokane Wash RFD #7

15. Filed June 5, 1929 W. J. Steurges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8, 1929, to April 2, 1929
that I last saw her alive on April 1, 1929
and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Frank Stacy, M. D.
4/6. 1929 (Address) Rathdrum, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Grove Cemetery	4-7 1929

20. Undertaker	Address
Crosedy Funeral Home	Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66267

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Hill

(a) Residence. No. Potlatch Hospital St. 127
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: C. R. Hill

6. DATE OF BIRTH (month, day and year): July 19 1883

7. AGE: Years 46 | Months 9 | Days 8 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10. NAME OF FATHER: J. Nicolay

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Friederika Rieth

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa.

14. Informant: C. R. Hill
(Address) Palouse Wash

15. Filed April 29, 1929 Geo. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1929, to April 27, 1929, that I last saw her alive on April 27, 1929, and that death occurred, on the date stated above, at 5:30 p m.

The CAUSE OF DEATH* was as follows:
Acute Ileus following
Cholecystectomy
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of April 23, 1929
Was there an autopsy? No
What test confirmed diagnosis? V

(Signed) F C Gibson, M. D.
4/29/, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wash	April 30 1929
20. Undertaker	Address
Ed H. Irwin	Palouse Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66268

Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.

PLACE OF DEATH
County of Latah
City of Onaway
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Edna Bull

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 23 1898

7. AGE — Years: 30 | Months: 8 | Days: 20 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Saw Mill
(c) Name of employer: Palladen Lum. Co.

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: Albert Bull
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Minnesota
12. MAIDEN NAME OF MOTHER: Leslie Hart
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Albert Bull
(Address): Palladen Ida

15. Filed May 14th, 1929. J. Geo. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 13 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to May 13, 1929
that I last saw h[illegible] alive on May 13, 1929
and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:
Chronic Rheumatic Endo and Myocarditis with Complete Decompensation
(duration) 5 yrs. approx mos. ds.
CONTRIBUTORY (Secondary) Acute Decompensation with General Edema (duration) yrs. 2 mos. approx ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History + General Physical Exam
(Signed) Hyden Hamilton, M. D.
May 16, 1929 (Address) Potlatch - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Greer & Green. Date of Burial: May 15 1929
20. Undertaker: J. W. Irwin Address: Palouse Wash

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED JUN 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 86269

Registered No.

1. PLACE OF DEATH

County of Latah

City of Princeton

Registration District No. 65

Primary Registration District No. 2145

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dewey Ellsworth Discon.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male.	White	single

6. DATE OF BIRTH: March (Month) 17 (Day) 1927 (Year)

7. AGE: Yrs. 1 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Potlatch

10. NAME OF FATHER J. M. Discon.

11. BIRTHPLACE OF FATHER (State or Country) Idaho (Wardner)

12. MAIDEN NAME OF MOTHER Lillian Trotter

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Discon.
(Address) Princeton

15. Filed May 3 1929 D. Jos. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 19..., to ✓ 19...
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Not Known. — probable
Acute enlarged thymus.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ✓

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Thompson M. D.
5/3/1929 (Address) Potlatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Potlatch Cemetery	May 4th 1929
20. UNDERTAKER E Irwin	ADDRESS Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JUN 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66270

Registration District No. 64
Primary Registration District No. 2144
Local Registrar's No.

PLACE OF DEATH
County of Latah
City of Troy Ida
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Axel Johnsoon

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74 M

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Mrs Axel Johnsoon

6. DATE OF BIRTH (month, day and year): 1869 — March 23

7. AGE: Years 60 | Months 2 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laboror
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: John Andersoon
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Mrs Axel Johnsoon
(Address) East 1702 Richabee Spokane Wash

15. Filed May 31, 1929. Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 27 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1929 to May 27, 1929
that I last saw him alive on May 26, 1929
and that death occurred, on the date stated above, at 5:29 m.
The CAUSE OF DEATH* was as follows:
Apoplexy.
Cerebral Hemorrhage.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Chas. A. Meyer, M.D.
May 27, 1929 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane Wash. Date of Burial: May 29 1929
20. Undertaker: John J. Pickerd Address: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66271

PLACE OF DEATH

County of Latah

City of Genesee

CERTIFICATE OF DEATH

Registration District No. 62

Primary Registration District No. 2142

(No.) 88

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

2. **FULL NAME** Inga Martinson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Martinson

6 DATE OF BIRTH (month, day and year) April 5, 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER J. Gilbertson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Henry Martinson
(Address) Genesee Ida.

15 Filed May 23, 1929 W. H. Ehlen Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 21, 1929 (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1928, to May 21, 1929, that I last saw her alive on May 20, 1929, and that death occurred, on the date stated above, at 5A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Fatty Degeneration

Heart (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diag.

(Signed) H. B. Stockslager M. D.

5/21, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Genesee, Ida.	5/23/29 19

20. Undertaker	Address
H. R. Short	Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66272

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Latah
City of Moscow
Registration District No. 101
Primary Registration District No. 2041
(No. Latah County Home)
Local Registrar's No. 28
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mathew Cooney

(a) Residence. No. [illegible] St. 101
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	80			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Common laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not known

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) (State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant L.P. Hunt
(Address) Moscow, Idaho

15 Filed May 11, 1929 W. H. Weathers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 4, 1929 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 1924, to May 4, 1929, that I last saw [illegible] alive on May 4, 1929, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) ___ yrs. ___ mos. 5 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical signs

(Signed) J. W. Stevenson, M. D.
5/6 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow	5/7/29 19

20. Undertaker F. R. Short — Address Moscow

RECEIVED JUN 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66273

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 121
Primary Registration District No. 1011
(No. _____)

Local Registrar's No. 29

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME LORA FLORENCE DREW

(a) Residence. No. 9 St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6 DATE OF BIRTH (month, day and year) May 8, 1927.

7 AGE Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
2	0	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Oaksdale Washington

PARENTS

10 NAME OF FATHER John L/ Drew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tyler, Wn.

12 MAIDEN NAME OF MOTHER Libbie Chadek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Moscow, Ida.

14 Informant John L. Drew
(Address) Moscow Ida.

15 Filed May 28, 1929 W. H. Carithers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 27 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1929, to May 27, 1929, that I last saw her alive on May 27, 1929, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:
Whooping Cough
(duration) yrs. mos. 20 ds.
CONTRIBUTORY (Secondary) Double Pneumonia
(duration) yrs. mos. 36 hrs. ds.

18 Where was disease contracted if not at place of death? On R.F.D. #5 home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No

(Signed) L. D. Magee M. D.
May 28 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow Ida.	5-29 1929
20. Undertaker W. R. Short	Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M-1-19

RECEIVED JUN 12 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66275

Local Registrar's No.

1. PLACE OF DEATH
County of Latah
City of Cameron
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No.
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert K. Stubbs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Oct. 26 1852 (Month) (Day) (Year)

7. AGE: 76 Yrs. 6 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Germany

10. NAME OF Father: John Stubbs

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Florence Stubbs
(Address) Cameron Idaho

15.
Filed April 27 1929 W. F. Nesbit
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 26, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1927 to Apr. 26 1929, that I last saw h[illegible] alive on Apr. 5 1929, and that death occurred on the date stated above, at 12:35 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of Rectum with metastasis.
(Duration) 2 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Olney Morehead M. D.
4-27-1929 (Address) Kendrick, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cameron — DATE OF BURIAL: April 29 1929

20. UNDERTAKER: J. J. Packard — ADDRESS: Troy, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66276

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Robert Andrew Finlay 170
(a) Residence. No. Salmon Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucy Sewell Finlay

6. DATE OF BIRTH (month, day and year): June 6th 1882

7. AGE: Years 46 | Months 9 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer): Day Laborer
(c) Name of employer: Walter Fox

9. BIRTHPLACE (city or town) (State or country): Kansas

PARENTS
10. NAME OF FATHER: Robert Finlay
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Margret Carswell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: Mrs Lucy Sewell Finlay
(Address): Salmon, Idaho

15. Filed 5/10, 1929. Chas Bellamy, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 1st (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at Not known m.
The CAUSE OF DEATH* was as follows: Gun shot wound in head with suicidal intent.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) William C. Doebler Coroner
May 1st, 1929 (Address) Salmon, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery | Date of Burial: May 4th 1929

20. Undertaker: Wm C. Doebler | Address: Salmon Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 1 0 1929

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66277

PLACE OF DEATH

County of Lemhi

City of Salmon

Registration District No. 41

Primary Registration District No. 2116

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Edward V. Manfull

(a) Residence. No. Water St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 42 yrs. 10 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Cauc

5. Single, Married, Widowed, or Divorced (write the word): Divorced.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Vena Adams

6. DATE OF BIRTH (month, day and year)

7. AGE: 45 yrs. Months: 10 Days: 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: farming

(b) General nature of industry, business, or establishment in which employed (or employer): general farm work

(c) Name of employer: Sam Hixon

9. BIRTHPLACE (city or town) (State or country): Salmon Idaho

PARENTS

10. NAME OF FATHER: Stephen G. Manfull

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Columbus Ohio.

12. MAIDEN NAME OF MOTHER: Neomia Clemmons

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: R. Owen Swift

(Address): Salmon Ida.

15. Filed 5/10 - 1929 Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr 24th (Month) 24th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby, 1928, to Apl 24, 1929 that I last saw him alive on Apl 17, 1929 and that death occurred, on the date stated above, at 10 40 a.m.

The CAUSE OF DEATH* was as follows:

Cause of face

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) P. Wright, M. D.

Apl 24, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery

Date of Burial: 4-26th 1929

20. Undertaker: Wm C. Doehler

Address: Salmon Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66278

PLACE OF DEATH

County of Lemhi

City of ~~Salmon~~ May Idaho

Registration District No. 41

Primary Registration District No. 2116

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

188C

2. FULL NAME Richard Whiteaker

(a) Residence. No. May, Idaho St. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1909, March 17

7. AGE Years 20 Months 2 Days 10 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ranch hand

(b) General nature of industry, business, or establishment in which employed (or employer) Woods Livestock Co.

(c) Name of employer Mr Lambson

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Scott

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Howard McIntosh
(Address) May Idaho

15. Filed June 10, 1929 Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw him alive on , 19

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows: Resulted from automobile accident. Death caused by some heart lesion; no post mortem was held (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. L. Kirtley, M. D.

May 30, 1929 (Address) Challis, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sol May Cemetery

Date of Burial 19

20. Undertaker Wm. C. Doebler

Address Salmon

RECEIVED JUN 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66279

PLACE OF DEATH

County of Lemhi
City of Salmon
Registration District No. 41
Primary Registration District No. 2116
Local Registrar's No.
(No. Salmon General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Francis Glavine

(a) Residence. No. Gilmore Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

18

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Georgia Anna Glavine

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
sixty	3	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dairyman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Marseilles Ill.
(State or country)

PARENTS

10. NAME OF FATHER James Glavine
11. BIRTHPLACE OF FATHER (city or town) Ireland
(State or Country)
12. MAIDEN NAME OF MOTHER Mary Maher
13. BIRTHPLACE OF MOTHER (city or town) Ireland
(State or Country)

14. Informant Mrs T E Allan
(Address) Challis Idaho.

15. Filed June 10, 1929 Clio Bellamy
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 27th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1929, to May 27, 1929, that I last saw h[illegible] alive on May 27, 1929, and that death occurred, on the date stated above, at 5 P— m.

The CAUSE OF DEATH* was as follows:
Rocky Mountain Spotted Fever
(duration) yrs. mos. 28 ds.
CONTRIBUTORY (Secondary) Phlebitis
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Gilmore
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hamm, M. D.
May 27, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gilmore Cemetery	5-29 1929
20. Undertaker	Address

MARGIN RESERVED FOR [redacted] PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE BECOMES A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 13 1929

PLACE OF DEATH

County of Lemhi

City of Salmon

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 41

Primary Registration District No. 2116

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66280

Local Registrar's No. .....

2. FULL NAME Marie Kerdner

(a) Residence. No. Salmon, Idaho St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

126

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 32 Months 7 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Chillicothe Mo

PARENTS

10. NAME OF FATHER: James Mahaffey

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Margaret Delaney

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kansas

14. Informant: Mrs. Margaret Mahaffey

(Address) Oakland Calif.

15. Filed June 10, 1929 Cho Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl 10th, 1929, to May 26th, 1929 that I last saw her alive on May 26th, 1929 and that death occurred, on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) X yrs. 18 mos. 18 ds.

CONTRIBUTORY (Secondary) Pelvic Infection

(duration) yrs. 1 mos. 18 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] Wright M. D.

5/29, 1929 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery

Date of Burial: 5-28th 1929

20. Undertaker: Wm C. Doebler

Address: Salmon Ida

RECEIVED JUN 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66281

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John E. Schultz 43
(a) Residence, No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE: About 65 Years | Months | Days | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Penn.

PARENTS
10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: R. M. Twiss
(Address): Salmon Ida

15. Filed June 10, 1929 Otto Billam Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 24th (Month) (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 19, 1929, to May 24, 1929
that I last saw him alive on May 24, 1929
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Cancer of lip-face and jaw
about 3 years (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
May 27, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery
Date of Burial: 5-24th 1929
20. Undertaker: Wm C. Doebler
Address: Salmon Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66282

PLACE OF DEATH
County of Lemhi
City of Gilbertsville
Registration District No. 4
Primary Registration District No. 2116
Local Registrar's No.
(No. 44)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Ashworth

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64 y	2	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Diggings, Wis.

PARENTS

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Wm. C. Doebler
(Address) Salmon Idaho

15. Filed June 6, 1929 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 15th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to Apr. 7, 1929
that I last saw him alive on April 7, 1929
and that death occurred, on the date stated above, at 5-30 p.m.
The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

about 2 years (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Clar F Hamner, M. D.
May 27, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gilbertsville Cemetery	4-17th 1929

20. Undertaker Wm C Doebler Address Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 13 1929

PLACE OF DEATH

County of Lewis

City of Russel Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 47

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66283

Local Registrar's No. 142

2. FULL NAME Dick Wells

(a) Residence. No. Lewis Co. Russell Ridge St. 110

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of George Wells

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) V

(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Pike Co, Mo.

PARENTS

10. NAME OF FATHER Merritt

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Ann Merritt

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant George W Wells

(Address) Russel Idaho

15. Filed June 8, 1929 Albert Huff Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 24 (Day) 29 (Year), 19

17. I HEREBY CERTIFY, That I attended deceased from June 9th, 1928, to Apr 24, 1929

that I last saw h[illegible] alive on April 23rd, 1929

and that death occurred, on the date stated above, at 545 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia. Flu (Terminal)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Valvular heart lesion

(duration) yrs. 11 mos. ds.

18. Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of V

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) W. R. Stratton, M. D.

4/25, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rosalia Wash	April 6 1929
20. Undertaker	Address
Albert Huff	Moscow Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66284

PLACE OF DEATH
County of Lincoln
City of Shoshone

Registration District No. 16
Primary Registration District No. 1016
Local Registrar's No. 9

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lena A Reedy

(a) Residence. No. F J Burdett St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

129

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph H Reedy

6. DATE OF BIRTH (month, day and year): Nov 7 1879

7. AGE: Years 49 | Months 5 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Siolam Spgs Ark

PARENTS

10. NAME OF FATHER: Wm McCann
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New Orleans
12. MAIDEN NAME OF MOTHER: Mary Morrison
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Jim Reedy
(Address): Fairfield Idaho

15. Filed: Apr 16, 1929 J L Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to April 15, 1929
that I last saw her alive on April 15, 1929
and that death occurred, on the date stated above, at 7.30 A m.
The CAUSE OF DEATH* was as follows:
Empyemae with Septicemia and Meningeal involvement
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Aspiration Date of 4/10/29
Was there an autopsy? no
What test confirmed diagnosis? Aspiration Timbar
(Signed) puncture F. E. Barrett, M. D.
4/15, 1929 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fairfield Idaho | Date of Burial: April 17 1929

20. Undertaker: C E Hickok | Address: Shoshone Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED MAY 15 1929

PLACE OF DEATH

County of Lincoln
City of ~~Idaho~~ Shoshone

CERTIFICATE OF DEATH

Registration District No. 16
Primary Registration District No. 1016
(No. W C Custer Ranch)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 66285

Local Registrar's No. 7

2. FULL NAME Nettie Eastabrook

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wotford Eastabrook

6 DATE OF BIRTH (month, day and year) April 23, 1849

7 AGE: Years 79 | Months 11 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bradford County Penn.

PARENTS
10 NAME OF FATHER Hyland Chafey
11 BIRTHPLACE OF FATHER (city or town) (State or country) New York State
12 MAIDEN NAME OF MOTHER Eliza Humphrey
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant L J Eastabrook
(Address)

15 Filed Apr 12, 1929 J L Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH. April (Month) 11 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to April 10, 1929 that I last saw her alive on April 10, 1929 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Phy Exam
(Signed) T. E. Barrett, M. D.
4/12, 1929 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rockland Idaho
Date of Burial: 19

20. Undertaker: C E Hickok
Address: Shoshone Ida

WRIT ENT RECORD

N. B.—Every item of information s e. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66286

PLACE OF DEATH
County of Lincoln
City of Idaho

Registration District No. 16
Primary Registration District No. 1016
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Calvin L Baker

(a) Residence. No. Ranch 13 Mi NW Shoshone St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna E Baker

6 DATE OF BIRTH (month, day and year): Dec. 19, 1869

7 AGE: Years 59 | Months 3 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington Ills

PARENTS
10 NAME OF FATHER: Thos L Baker
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: Julia Tobias
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Anna E Baker
(Address)

15 Filed Apr 23, 1929 J L Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 11 (Day) 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw h..... alive on ..... 19...,
and that death occurred, on the date stated above, at 12 p.m.
Did not attend
Dead when arrived

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(History of Heart Trouble)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no Exam indicated Heart attack
What test confirmed diagnosis? Phy Exam
(Signed) F. E. Barrett, M. D.
4/12, 1929 (Address) Shoshone

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Shoshone Idaho
Date of Burial: April 14 1929

20. Undertaker: C E Hickok
Address: Shoshone Ida

FORM V. S. No. 5-25 M. 1-19

RECEIVED JUN 10

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

66284

1. PLACE OF DEATH

County Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

State File No. .....

Local Registrar's No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl Abraham Palmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word)

6. DATE OF BIRTH: May (Month) 21 (Day) 1875 (Year)

7. AGE: 54 Yrs. ..... Mos. 14 ds. .....

IF LESS than 1 day how many ✓ hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF Father: Hyrum Palmer

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Carlson

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah Olivia Palmer
(Address) Chester Idaho.

15. Filed 6/5 1929 J. Ryoung Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1929, to June 5 1929 that I last saw him alive on June 5 1929 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Artero sclerosis

(Duration) 1 yrs. ..... mos. ..... ds.

6/5 (Signed) Lorin F. Rich M. D.

1929 (Address) Rexburg Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilford — DATE OF BURIAL: June 9 1929

20. UNDERTAKER: H. W. Hanson — ADDRESS: St. Anthony Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66288

PLACE OF DEATH

County of Madison
City of Rexburg

CERTIFICATE OF DEATH

Registration District No. 100
Primary Registration District No. 2178
(No.) Local Registrar's No. 45
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME John Wolfley

(a) Residence. No. St. 31
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White.
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) April 26, 1901

7 AGE: Years 28 | Months 1 | Days 15 | If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Switzerland

PARENTS
10 NAME OF FATHER: Christian Wolfley
11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland
12 MAIDEN NAME OF MOTHER: Margret Schmocker
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant: Mrs Christian Wolfley
(Address) Rexburg Idaho

15 Filed 6/5, 1929 J Ryoung Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 5 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to June 5, 1929, that I last saw him alive on June 3, 1929, and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 2 or 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Farley Nelson M. D.
June 5, 1929 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rexburg Cemetery. Date of Burial: 6/7 1929

20. Undertaker: A B Eckersell Address: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66289

PLACE OF DEATH
County of Madison
City of Sugar City

Registration District No. 100
Primary Registration District No. 278
(No.)

Local Registrar's No. 44

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME James H. Park

(a) Residence. No. 89 St.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Maria Park

6 DATE OF BIRTH (month, day and year) June 15/1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	11	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Utah.

PARENTS
10 NAME OF FATHER James Park
11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland
12 MAIDEN NAME OF MOTHER Miss. Findley
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Clarence Park
(Address)

15 Filed 6/25, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 5 (Month) 25 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 5-25, 1927, to 5-25, 1929, that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
accident
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no

(Signed) [illegible], M. D.
5-25, 1929 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Sugar City Cemetary — Date of Burial: 5/29 1929

20. Undertaker [illegible] — Address [illegible] Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66290

PLACE OF DEATH
County of Madison
City of Hibbard

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 43

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George McCulloch

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

88b

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Catharine McCulloch

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 71, Months 8, Days 21. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10. NAME OF FATHER: Henry McCulloch
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Mary Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: Catharine McCulloch
(Address) R 3 Rexburg

15. Filed 5/27, 1929 J Ryan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1928, to May 10, 1929
that I last saw him alive on May 10, 1929
and that death occurred, on the date stated above, at a. m.
The CAUSE OF DEATH* was as follows:
Cardio-renal-vascular disease
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary): Acute dilation of heart
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? symptoms
(Signed) Louis S Rich, M. D.
5-27-, 1929 (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rexburg Idaho
Date of Burial: May 28 1929

20. Undertaker: H. T. Gibson #133
Address: Rexburg

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66291

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 100
Primary Registration District No. 278
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 42

119

2. FULL NAME Elsie Jean Bybee

(a) Residence. No. Lyman St. Idaho
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	2	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10. NAME OF FATHER Norman Bybee
11. BIRTHPLACE OF FATHER (city or town) Roseville
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Hazel Tompkins
13. BIRTHPLACE OF MOTHER (city or town) Centerville
(State or Country) Oklahoma

14. Informant Curtis G. Tompkins
(Address) Blackfoot Idaho

15. Filed 5/20, 1929 J. Rymer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to May 19, 1929
that I last saw her alive on May 19, 1929
and that death occurred, on the date stated above, at 6 30 a. m.
The CAUSE OF DEATH* was as follows:
Pleurisy

(duration) ..... yrs. ..... mos. 19 ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Carley Nelson M. D.
May 20, 1929 (Address) Ryburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19

20. Undertaker	Address
Elvin Keller	Ryburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66293

PLACE OF DEATH

County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 40

2. FULL NAME Addie Sharp
(a) Residence. No. 132 Rexburg St. Lee. W.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

24

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wife
6. DATE OF BIRTH (month, day and year)
7. AGE Years 45 Months 11 Days 25 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) West Verginia

PARENTS
10. NAME OF FATHER T.M. Lukins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Jennie Hughes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) West Verginia

14. Informant Clifford L. Sharp
(Address) Rexburg

15. Filed 5/19, 1929 J Rysonna Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11, 1929, to May 18, 1929
that I last saw her alive on May 18, 1929
and that death occurred, on the date stated above, at 2:00 P m.
The CAUSE OF DEATH* was as follows:
Cerebro-Spinal Meningitis
(duration) yrs. mos. ds.
Recovered fairly well then developed
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Spinal puncture & cultures
(Signed) H B Rigby, M. D.
May 19, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rexburg Cemetary
Date of Burial May 19 19
20. Undertaker Beneficial Mortuary Alvin Keller
Address Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66294

PLACE OF DEATH

County of Madison
City of Rexburg

CERTIFICATE OF DEATH

Registration District No. 100
Primary Registration District No. 2178
(No.) Local Registrar's No. 39

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Joe Christensen

(a) Residence. No. St. 161a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Son of Nean Christensen

6 DATE OF BIRTH (month, day and year): May 13/1929

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Rexburg

PARENTS
10 NAME OF FATHER: Nean Christensen
11 BIRTHPLACE OF FATHER (city or town) (State or country): Malad Idaho
12 MAIDEN NAME OF MOTHER: Maud Maulton
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Utah

14 Informant: Nean Christensen
(Address): Victor Idaho

15 Filed 5/14, 1929 J Young Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 13 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1928, to May 13, 1929, that I last saw him alive on May 13, 1929, and that death occurred, on the date stated above, at 1:00P m.

The CAUSE OF DEATH* was as follows: Prematures, (6½ mos.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Nephritis in mother. Mother had one kidney removed, come in with high fever, + urine loaded with albumen

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H B Rigby, M. D.
May 14, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Victor Idaho
Date of Burial: 19

20. Undertaker: C B Eckersell
Address: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66295

PLACE OF DEATH

County of Fremont

City of Teton

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 38

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

886

2. FULL NAME Mary Louise Owens

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Robert Owens

6. DATE OF BIRTH (month, day and year)

7. AGE: 56 Years | Months: I | Days: 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Parigonia Utah

PARENTS

10. NAME OF FATHER: D. A. Lamoreux

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Mary Louise Lamoreux

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: Thomas Robert Owens
(Address)

15. Filed 5/7, 1929 J. Myoung Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to May 6, 1929 that I last saw her alive on May 6, 1929 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows: Myocarditis

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) M. Sutherland, M. D.

5-7, 1929 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Teton-Cem- | Date of Burial: 19

20. Undertaker: Alvin Keller | Address: Rexburg

FORM V. S. [illegible] RECEIVED JUN 7 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

66296

1. PLACE OF DEATH

County of Nez Perce

City of Gifford

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 92

Primary Registration District No. 2170

(No. ..... , ... St.)

File No. .....

Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widowed (Write the word.)

6. DATE OF BIRTH: Aug (Month) 11 (Day) 1853 (Year)

7. AGE: 75 Yrs. 9 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: hwfe

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: John Sinclair

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Elisabeth Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse Campbell

(Address) Gifford

15. Filed 5-24 1929 E. E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1926, to May 23 1929 that I last saw her alive on May 21 1929, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Softening of Brain

..... (Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) Cerebral hemorrage

..... (Duration) 3 yrs. — mos. — ds.

(Signed) E. E. Watts M. D.

5-24 1929 (Address) Gifford Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Melrose

DATE OF BURIAL: 5-25 1929

20. UNDERTAKER: Brower and Wann

ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 86297
Registered No. 10

1. PLACE OF DEATH

County of Oneida

City of Malad

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Earl Gibbons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Child

6. DATE OF BIRTH: Oct. (Month) 9 (Day) 1916 (Year)

7. AGE: 2 Yrs. 7 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Malad Ida.

10. NAME OF FATHER James Evan Gibbons

11. BIRTHPLACE OF FATHER (State or Country) Ogden Ut.

12. MAIDEN NAME OF MOTHER Ethel Thomas

13. BIRTHPLACE OF MOTHER (State or Country) Malad Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John Hendrew

(Address) Malad Ida

15. Filed 5/31 1929 J. M. Nervo Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1929, to May 31, 1929, that I last saw him alive on May 31 1929, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Meningitis due To Colon Bacilli Infection.

(Duration) ..... Yrs. 36 hrs. ..... mos. ..... ds.

Contributory (Secondary) Enteritis

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) V. J. Grant M. D.

June 1, 1929. (Address) Bradley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Cem	June 2 1929

20. UNDERTAKER	ADDRESS
J. Guy Benson	Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19

RECEIVED JUN 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida

City of Stone

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26

Primary Registration District No. 2069

(No. ..... St.)

File No. 66298

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Boley Showell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 6 (Day) 1929 (Year)

7. AGE: X Yrs. X Mos. X ds.

IF LESS than 1 day how many 5 hrs. or 55 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Stone Idaho.

10. NAME OF FATHER: Rollin Showell

11. BIRTHPLACE OF FATHER (State or Country): Stone Idaho.

12. MAIDEN NAME OF MOTHER: Effie Elnor Young

13. BIRTHPLACE OF MOTHER (State or Country): Mona Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rollin Showell

(Address) Stone Ida

15.

Filed ..... 19.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1929 to May 6 1929 that I last saw him alive on May 6 1929 and that death occurred on the date stated above, at 1:30 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Stenosis
(Congenital Heart Lesion)
Blue baby

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) 2 Wks premature

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. Pedardleighner M. D.

..... 19..... (Address) Snowville Utah

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Snowville

DATE OF BURIAL: May 7 1929

20. UNDERTAKER: Jos J Larkin

ADDRESS: Snowville UT

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 6 1929

CERTIFICATE OF DEATH 26

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida

City of Malad

Registration District No.

Primary Registration District No. 2069

(No. , St.)

File No. 66299

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dona Kathleen Clark.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Oct. 24 1928 (Month) (Day) (Year)

7. AGE: Yrs. 7 Mos. 16 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad Ida.

10. NAME OF FATHER: Hugh L. Clark.

11. BIRTHPLACE OF FATHER (State or Country): Portage Utah.

12. MAIDEN NAME OF MOTHER: Sarah Jundell.

13. BIRTHPLACE OF MOTHER (State or Country): Woodruff. Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. L. Clark

(Address) R.F.D. # 2 Malad

15. Filed 5/31 1929 J. M. Kerns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 10 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1929 to May 10 1929 that I last saw her alive on May 9 1929 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary): none

(Duration) yrs. mos. ds.

(Signed) W. M. Walker M. D.

5/11 1929 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Cem. DATE OF BURIAL: May 12 1929

20. UNDERTAKER: J. Guy Hansen ADDRESS: Maladcity

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 6 1

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

66301

1. PLACE OF DEATH

County of Oneida

City of Malad

If death occurs away from usual residence, give facts called for under special information.

Registration ct 26

Primary Registration strict No. 2569

(No. , St.)

File No.

Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: April (Month) 10 (Day) 1869 (Year)

7. AGE: 60 Yrs. 0 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Wales

10. NAME OF FATHER: Thomas Jones

11. BIRTHPLACE OF FATHER (State or Country): Wales.

12. MAIDEN NAME OF MOTHER: Jane Moses

13. BIRTHPLACE OF MOTHER (State or Country): Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ✓ W. H Jones

(Address) Malad Ida

15. Filed 5/31 1929 J. M. Kerns Local Registrar

MEDICAL CERTIFICATE OF DEATH

885

16. DATE OF DEATH: May (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1929, ~~to ..... 19..~~ that I last saw her alive on May 2 1929 and that death occurred on the date stated above, at 3P M.

The CAUSE OF DEATH* was as follows: Curvated a life time from birth Myocarditis

(Duration) ? Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

5/8 1929 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Ida

DATE OF BURIAL: May 10 1929

20. UNDERTAKER: J. Guy Benson

ADDRESS: Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66302

PLACE OF DEATH

County of Owyhee
City of Homedale

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 32

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Jane Reynolds

(a) Residence. No. Homedale, Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of G. R. Reynolds

6. DATE OF BIRTH (month, day and year) May 10 1845

7. AGE: 83 Years, 11 Months, 8 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10. NAME OF FATHER: S. D. Gibbs
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: E. C. Reynolds
(Address) Homedale Ida

15. Filed 4-22-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1929, to April 18, 1929
that I last saw her alive on March 16, 1929
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis
(duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) V C Beetnoff, M. D.
Apr 20, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: April 22 1929

20. Undertaker: C. V. Peckham
Address: Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66303

PLACE OF DEATH
County of Owyhee
City of Melba

Registration District No. 107
Primary Registration District No. 2185
Local Registrar's No. 1
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Elizabeth Young.
(a) Residence. No. Melba Ida St. 101 a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of C. F. Young.
6. DATE OF BIRTH (month, day and year) Nov. 30-1867
7. AGE Years 61 Months 5 Days 16 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) missouri
PARENTS
10. NAME OF FATHER Mr. Martin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER Hatfield
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known
14. Informant W. V. Young
(Address) Huston #1 Ida.
15. Filed May 18, 1929 Robert E Talbot Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 16 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to no M.D. attended, 19...
that I last saw h..... alive on ....., 19...
and that death occurred, on the date stated above, at 2-P. m.
The CAUSE OF DEATH* was as follows:
Labor Pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? — Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Robert E Talbot, M. D.
May 18, 1929 (Address) Welder Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Knowlton Higher. Date of Burial 5/17 1929
20. Undertaker C. V. Peckham Address Caldwell, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66304

Local Registrar's No. 45

1. PLACE OF DEATH

County of Owyhee

City of Bruneau

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 74

Primary Registration District No. 2151

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JUN 4 1929

2. FULL NAME Fletcher Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	single

6. DATE OF BIRTH December (Month) 25th (Day) 1849 (Year)

7. AGE 79 Yrs. 4 Mos. 30 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Ranchman

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Taylorville, Iowa

10. NAME OF Father Jered Taylor

11. BIRTHPLACE OF FATHER (State or Country) Taylorville, Iowa

12. MAIDEN NAME OF MOTHER Isabel Lenz

13. BIRTHPLACE OF MOTHER (State or Country) Taylorville, Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Arendt

(Address) Indian Cove

15. Filed June 1st 1929 W J Eidenbenz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 24th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21st 1929 **to** ..... 19....,

that I last saw him alive on May 21st 1929

and that death occurred on the date stated above, at 11:00 M.

The CAUSE OF DEATH* was as follows:

Hemiplegia (cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm J Eidenbenz M. D.

5/27 1929 (Address) Grand View

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Bruneau

DATE OF BURIAL May 26 1929

20. UNDERTAKER C. F. Zacher

ADDRESS Mt. Home

RECEIVED JUN 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66305

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Payette

City of Payette

Registration District No. 4

Primary Registration District No. 1008

Local Registrar's No. 17

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME George H Hunter

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years 71 Months — Days 12 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ill

PARENTS

10 NAME OF FATHER John Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Farnham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant J H Edair

(Address) Payette Idaho

15 Filed May 13, 1929 J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar. (Month) 5 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 1927, to Mar 4, 1929, that I last saw him alive on Mar 4, 1929 and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Asthma

..... (duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J C Woodward M. D.

Mar 6, 1929 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Payette Ida

Date of Burial Mar 6 1929

20. Undertaker J H Edair

Address Peterson Furn Co Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66306

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008.
(No. 880)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

2. FULL NAME John P. Hailey.

(a) Residence. No. Boise St. Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 13. 1900

7. AGE	Years	Months	Days	If LESS than 1 day,
	28	6	15	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Manager J. Filley Estate
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wyoming.

PARENTS

10. NAME OF FATHER James Hailey.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Neb.
12. MAIDEN NAME OF MOTHER Mary E. Tobin.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mrs. C. A. Hoffman
(Address) Orchard St. Idaho

15. Filed May 27. 1929. J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 26, 1929
that I last saw him alive on May 26, 1929
and that death occurred, on the date stated above, at 9:00 p m.
The CAUSE OF DEATH* was as follows:
Endocarditis — Mitral insufficiency

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical + physical findings
(Signed) O. H. Avery, M. D.
May 27, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kuna Idaho.	May 30 1929
20. Undertaker	Address
Glenn C Sanders.	Payette Ida.

MARGIN RESERVED
WRITE PLAINLY, WITH UNFADING INK—THIS [illegible] RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66307

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 19

(No. 886)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucca Jacobsen.

(a) Residence. No. 1120 1st Ave. South St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 13 1847.

7. AGE: Years 81 | Months 6 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10. NAME OF FATHER Eric Assmusen.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Anna Baggendorf.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Mrs Lillie Sewell.
(Address)

15. Filed May 13, 1929 J. G. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 13, 1929, to May 4, 1929, that I last saw h[er] alive on May 6, 1929, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

indefinite (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Merrill R. Fox, M. D.
May 5, 1929 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette Ida.	May 6 1929
20. Undertaker	Address
Glenn C Landon.	Payette Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66308

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 18

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Esphraim W. Blakesley

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Marian Gardner Blakesley

6. DATE OF BIRTH (month, day and year):

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ill.

PARENTS

10. NAME OF FATHER: Nathaniel Blakesley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Crestinie Blackburn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant: R H Woods
(Address): Payette Ida

15. Filed May 13, 1929 J. O. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 27 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl. 22, 1929, to Apl. 27, 1929, that I last saw him alive on Apl. 27, 1929, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:
Fracture rt. hip

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? none

(Signed) Merrill R. Lo M. D.
May 4, 1929 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Payette. Ida. | Date of Burial: April 29 1929

20. Undertaker: Glenn C Landon. | Address: Payette Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 8

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66309

PLACE OF DEATH

County of Power
City of American Falls, Idaho
Registration District No. 26-
Primary Registration District No. 2072
Local Registrar's No. 14

(No.) 182
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nellie Katherine Grady

(a) Residence. No. Rockland, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J.R.Grady

6. DATE OF BIRTH (month, day and year) July 7th 1888

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	2		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colo

PARENTS

10. NAME OF FATHER Snow
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Teen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant J.R.Grady
(Address) American Falls, Ida

15. Filed May 13, 1929 Genevieve Noble Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 11th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not see to her during 19 to 19 that I last saw her alive on March 7th 1929 and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows: Because she was under the care of Dr. Valvular Heart disease (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Edema of lungs (duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History given by family

(Signed) C. F. Schiefer, M. D.
5/11/29, 19 (Address) Am. Falls. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F. Cem Am Falls	5/13/29 19
20. Undertaker A. W Davis	Address American Falls

Id

RECEIVED JUN 7 1929

66310

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 28

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

916

2. FULL NAME Stella Power Wilson

(a) Residence. No. 1173 McKinley Avenue St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of Samuel C. Wilson

6. DATE OF BIRTH (month, day and year): Dec 25-1849

7. AGE: Years 79 | Months 5 | Days 3 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Aberdeen - Ohio

PARENTS

10. NAME OF FATHER: Captain Ryas Power
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.
12. MAIDEN NAME OF MOTHER: Rebecca Wright Power
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn.

14. Informant: Mrs. Harry Wilson
(Address) Kellogg - Ida -

15. Filed May 31, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1928, to May 29, 1929, that I last saw her alive on May 28, 1929, and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:
Arterio-sclerosis, cerebral type
(duration) yrs. 8 mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Leon + Kennett, M. D.
May 30, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane Nash | Date of Burial: June 1 1929

20. Undertaker: M. C. Thornhill | Address: Kellogg - Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 7 1929

PLACE OF DEATH

County of Shoshone

City of Kellogg

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 123

Primary Registration District No. 2201

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 66311

Local Registrar's No. 26

2. FULL NAME Robert Mills

(a) Residence. No. 611 - 2nd St. 201
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 6 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Myrtle Endrup Mills

6. DATE OF BIRTH (month, day and year) Jan 11 - 1893

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36	4	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clr. - Foreman -

(b) General nature of industry, business, or establishment in which employed (or employer) B. M. & S. -

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minneapolis Minn

PARENTS

10. NAME OF FATHER John Mills

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ulster Penn.

12. MAIDEN NAME OF MOTHER Rose Voorhees -

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mansfield Pa.

14. Informant Mrs. Myrtle Mills

(Address) Kellogg - Ida

15. Filed 5/23, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1929, to May 22, 1929

that I last saw h~~im~~ alive on May 22, 1929

and that death occurred, on the date stated above, at 7:54 P. m.

The CAUSE OF DEATH* was as follows:

Compound comminuted Skull fracture

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 21

Was there an autopsy? no

What test confirmed diagnosis? Opinion

(Signed) Geo. T. Kennett M. D.

May 23, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane, Wash	May 27, 1929
20. Undertaker M. C. Thornhill	Address Kellogg Idaho

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Dr. Kennett

DO NOT WRITE IN THIS SPACE
State File No. 66312

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 25

2. FULL NAME Aileen Joy Heineman

(a) Residence. No. ..... St. 100 a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 5, 1928

7. AGE Years | Months 7 | Days – | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg Idaho

PARENTS
10. NAME OF FATHER Myron W. Heineman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Jessie Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Dakota

14. Informant Myron W Heineman
(Address)

15. Filed May 30, 1929 Mrs. Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28, 1929, to May 5, 1929
that I last saw her alive on May 5, 1929
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(duration) ..... yrs. ..... mos. 14 ds.
CONTRIBUTORY (Secondary) Gastro enteritis
(duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) Geo H Kennett, M. D.
May 7, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Greenwood | Date of Burial: May 7 1929

20. Undertaker: M C Sharshill | Address: Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66313

PLACE OF DEATH
County of Shoshone
City of Kellogg.

Registration District No. 123
Primary Registration District No. 3201
(No. ....)
Local Registrar's No. 24

182

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Earl Carter

(a) Residence. No. 142 Railroad Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 20-1925

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	8	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scobey, Mont.

PARENTS

10. NAME OF FATHER Arthur Carter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Grantsburg Wisconsin
12. MAIDEN NAME OF MOTHER Mary Simmons
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lanesboro Minn.

14. Informant Arthur Carter
(Address) Kellogg Ida

15. Filed May 30, 1929. Mrs. Helen M. Bride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw him alive on ..., 19...
and that death occurred, on the date stated above, at 12:15 P.M.
The CAUSE OF DEATH was as follows:

Bowel Abscess
Kellogg Ida
Gallstones
Kellogg Ida

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) M. Merrill Cox M.D.
5/4, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Ida	May 4 1929
20. Undertaker O. L. Stout	Address Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66314

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 23
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

163

2. FULL NAME Forest Fredrick Miles
(a) Residence. No. Kellogg Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 2 - 1929

7. AGE Years ~~1929~~ Months ~~Mo~~ 2 Days ~~mos 2~~ If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg - Ida

PARENTS
10. NAME OF FATHER Scott Miles.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hardy Ark.
12. MAIDEN NAME OF MOTHER Elsie Turner.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Cardstone Alt Canada

14. Informant Mrs. Scott Miles
(Address) Kellogg Idaho

15. Filed May 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 2, 1929
that I last saw her alive on May 1, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Mal Nutrition
No Care in feeding
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. R. Mason, M. D.
6, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg
Date of Burial May 4 1929

20. Undertaker R. L. Stout
Address Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66315

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1014
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 48

2. FULL NAME Lyman A Hannigan
(a) Residence. No. Carter House St. 49
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs L. A. Hannigan

6. DATE OF BIRTH (month, day and year)

7. AGE Years 70 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Aroostook Maine.

PARENTS
10. NAME OF FATHER David Hannigan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Lydia Trask Putnam
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Record from Hospital.
(Address) Wallace, Idaho

15. Filed May 9, 1929 J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1927, to Apl 3, 1929
that I last saw him alive on Apl 3 20, 1929
and that death occurred, on the date stated above, at 10:30 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Prostate

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phys. [illegible]
(Signed) [illegible] M. D.
5/8/29, 19 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Newberry, Mich. Date of Burial Shipped May 9-29
20. Undertaker J. A. Ewer Ward Und Co. Address Wallace, Idaho

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66316

PLACE OF DEATH

County of Shoshone
City of Stetson Sta

Registration District No. 20
Primary Registration District No. 011
Local Registrar's No. 47
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward E. Le Long

(a) Residence. No. ..... St. 182
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	?

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	45			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) ?

PARENTS

10. NAME OF FATHER ?
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ?
12. MAIDEN NAME OF MOTHER ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ?

14. Informant Metropolitan Insurance Co
(Address) In his possession

15. Filed May 6, 1929 E. E. Longley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Found.
Apr. (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Apr. 13 1929 to ~, 19.....
that I last saw h~ alive on Apr. 13, 1929
and that death occurred, on the date stated above, at a. m.

The CAUSE OF DEATH* was as follows:
accidental drowning
north fork of St. Joe River
at Stetson Station.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? examination
What test confirmed diagnosis? No Violence

(Signed) A. W. Wood Coroner
Apr 24, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Woodlawn	Apr. 20 1929
20. Undertaker	**Address**
Mitchell & Mungen	Mullan Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Dr Mowery

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66317

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 10 11

(No. Providence Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 41

2. FULL NAME Lazena Cleavinger

(a) Residence. No. 149 King Street St. 886

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan 28 1852

7 AGE: Years 77 | Months 3 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iddiana

PARENTS

10 NAME OF FATHER George Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Elsie Burges

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indiana

14 Informant G.W.Cleavinger

(Address) Wallace Idaho

15 Filed May 2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 30 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from apr 20, 1929, to apr 30, 1929, that I last saw her alive on apr 30, 1929, and that death occurred, on the date stated above, at 8 25 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage Right (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dr Mowery M. D.

5/1, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: United Cemetery Wallace Ida.

Date of Burial: 5/2 1929

20. Undertaker: Worstell Co

Address: Wallace

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66318

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Shoshone — Registration District No. 70

City of Wallace — Primary Registration District No. 10 11

(No. Shoshone County Infirmary)

Local Registrar's No. 45

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

105

2. FULL NAME Andrew P. Johnson

(a) Residence. No. Wallace Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Mar. 17 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	72	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Stockholm Sweeden

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweeden

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweeden

14 Informant Marie E. Lannon

(Address) Rockford Ill.

15 Filed Apr 27, 1929 T. F. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 29 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1929, to April 29, 1929, that I last saw him alive on Apr 28, 1929, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Bronchiae Asthma

4 years (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James R Bean, M. D.

4/29 1929 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rockford Illinois — Date of Burial 19

20. Undertaker Woodstell Co — Address Wallace

J S Shaughnessy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66319

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 44

PLACE OF DEATH
County of Shoshone
City of Wallace
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Flora Thomas Parker

(a) Residence. No. Wallace, Idaho. St. 89
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) March 5 1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	2	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rockford, Indiana

PARENTS
10. NAME OF FATHER Geo Thomas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Minerva Everton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Eugene Thomas
(Address) Wallace Idaho

15. Filed Apr 28 29 F. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25, 1929, to April 27, 1929, that I last saw h[e]r alive on April 27, 1929, and that death occurred, on the date stated above, at 2:15 m.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

4/29 (Signed) James R Reans, M. D.
1929 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	Apr 29 1929
20. Undertaker J. A. Bower	Address
Ward Und. Co.	Wallace, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66320

Local Registrar's No. 43

PLACE OF DEATH

County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Walter Turpina

(a) Residence. No. Mullan Idaho St. 1000

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of Industry, business, or establishment in which employed (or employer) Morning Mine

(c) Name of employer Federal Mining & Smeltering

9 BIRTHPLACE (city or town) (State or country) Finland

PARENTS

10 NAME OF FATHER John Turpina

11 BIRTHPLACE OF FATHER (city or town) (State or country) Finland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Finland

14 Informant Toivo Maki
(Address) Mullan Idaho

15 Filed Apr 28, 1929 J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 24 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 17 '29, to Apl 24, 1929,
that I last saw him alive on Apl 24, 1929,
and that death occurred, on the date stated above, at 2300 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apl 18 '29

Was there an autopsy? No

What test confirmed diagnosis? Phys Exam

(Signed) Grant L. Smith, M. D.

4-27-29, 19... (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Mullan Idaho	4/28/29
20. Undertaker Worstell Co. J. R. Shaughnessy	Address Wallace Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. Mowery

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66321

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Shoshone — Registration District No. 70

City of Wallace — Primary Registration District No. 1011

(No. Providence Hospital)

Local Registrar's No. 42

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

45

2. FULL NAME Arthur Tumlin

(a) Residence. No. Tamarack Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ethel Tumlin

6 DATE OF BIRTH (month, day and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer) Tamarack Mine

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER W.B.Tumlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Minnie Haynes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant Ethel Tumlin

(Address) Portland Oregon

15 Filed April 21, 1929 — T. K. Quigley, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 15 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Not, 1929, to Apr 15, 1929, that I last saw him alive on Apr 15 1929, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows: Coronary Thrombosis

Sandread

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr 26

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. W. Lawrence Hall, M.D.

4/19, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Eagles Plot Wallace Cemetery — Date of Burial: Apr. 21 19 29

20. Undertaker Worstell Co — Address: Wallace

J. J. Shaughnessy

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66322

PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 41

(No. 126)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Paul Jaatto

(a) Residence. No. Kingston Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Jaatto

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	7	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Finland.

PARENTS

10. NAME OF FATHER Matta

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland

12. MAIDEN NAME OF MOTHER Moring

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant Paul Jaatto

(Address) Hypotheek

15. Filed Apr 17 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 11th, 1929, to Apr 14, 1929

that I last saw her alive on Apr 14, 1929

and that death occurred, on the date stated above, at 6.50 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cholecystitis

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr 11th 1929

Was there an autopsy? No

What test confirmed diagnosis? General symptoms.

(Signed) W. L. Lindsay, M. D.

4/15, 1929 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Idaho	April 17 1929
20. Undertaker	**Address**
M. A. Thornhill	Kellogg, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66324

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1941
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 39

99 B

2. FULL NAME John Joseph Murphy

(a) Residence. No. Wallace, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White.	Widowed.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) July 22 - 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	9	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer N. P. R. Road.

9. BIRTHPLACE (city or town) (State or country) Poughkeepsie N. Y.

PARENTS

10. NAME OF FATHER John Murphy.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Not Known.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mrs Frances Crow.
(Address) Kellogg Idaho.

15. Filed April 16, 1929 E. R. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31, 1929, to April 13, 1929
that I last saw him alive on April 13, 1929
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Bronchitis

(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Diabetes Mellitus
(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

4/15, 1929 (Signed) James R Dean, M. D.
(Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	April 16 1929
20. Undertaker J. A. Bever	Address
Ward Undertaking Co.	Wallace Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REMAIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66325

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Shoshone
City of Mullan

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)

Local Registrar's No. 38

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mrs Jennie Nelson

(a) Residence. No. Earl St. St. Mullan, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Nelson

6 DATE OF BIRTH (month, day and year) Dec. 29, 1867

7 AGE Years 61 Months 3 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westprarie, Wis

PARENTS
10 NAME OF FATHER Henry Call.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway
12 MAIDEN NAME OF MOTHER not know
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Henry Nelson Son
(Address) Mullan Idaho

15 Filed April 15, 1929 A. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

94

16 DATE OF DEATH April (Month) 12 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from August, 1928, to April 12, 1929, that I last saw her alive on April 10, 1929, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis
(No T.B Present)

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Goiter.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. W. Rolfs, M. D.
April 15, 1929 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of ~~Burial, Cremation, or~~ Removal Virginia Wise ~~Wallace Ida~~ Date of Burial Shipped 4/16/29

20. Undertaker J. A. Bwer Ward Undertaking Co. Address Wallace Ida.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66326

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 37

2. FULL NAME E. M. Smith

(a) Residence. No. Wallace, Idaho St. Murray, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 90			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Retired.

9. BIRTHPLACE (city or town) (State or country) California.

PARENTS
10. NAME OF FATHER Not Known.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known.
12. MAIDEN NAME OF MOTHER Not Known.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known.

14. Informant Alvin Brunell.
(Address) Wallace, Idaho.

15. Filed Apr 14, 1929 W. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1928, to April 12, 1929
that I last saw h[illegible] alive on April 9, 1929
and that death occurred, on the date stated above, at 6:30 m.
The CAUSE OF DEATH* was as follows:

Myocarditis chr
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) old age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Dr. Maxwell M. D.
4/13, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	April 14 1929
20. Undertaker J. J. Bower Ward Undertaking Co.	Address Wallace, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66327

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 20
Primary Registration District No. 1011
(No.)

Local Registrar's No. 36

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME William Priddle

(a) Residence. No. Mullan, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Mullan, Idaho.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Federal Mng. Co.

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Not Known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs J. Leonard
(Address) Mullan, Idaho.

15 Filed April 13, 1929 L. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 11 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..., 1926 to April 11, 1929
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Stomach trouble
Contributory
(Secondary) Influenza
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. H. Woodard, M. D.
April 11, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho.	April 13 1929
20. Undertaker J. A. Bever	Address
Ward Undertaking Co.	Wallace, Idaho.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66328

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 35

2. FULL NAME George A. Richardson

(a) Residence. No. 904 Residence St. St.
(Usual place of abode)
(If nonresident give city or town and State)

49

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Black
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Anna Richardson

6 DATE OF BIRTH (month, day and year): July 24-1885

7 AGE: Years 43 | Months 5 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day Laboror
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS
10 NAME OF FATHER: Geo Richardson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia
12 MAIDEN NAME OF MOTHER: Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs Anna Richardson
(Address) Wallace, Idaho.

15 Filed Apr 13, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 11 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May, 1928, to Apr 11, 1929, that I last saw him alive on Apr 11, 1929, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Lower Jaw & Tongue
(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) R. A. Mowery, M. D.
4/12, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Wallace, Idaho
Date of Burial: April 13 1929

20. Undertaker: J. A. Bever Ward Undertaking Co.
Address: Wallace, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66329

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011

Local Registrar's No. 34

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ellen Racich

(a) Residence. No. 12 a E Brown St. 70
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. na mos. no ds. How long in U. S., if of foreign birth? 24 yrs. na mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: married Frank Racich

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28	—	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Jaska Croatia

PARENTS

10. NAME OF FATHER: Steve Suta
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Jaska Croatia
12. MAIDEN NAME OF MOTHER: Barbra Subar
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Jaska Croatia

14. Informant: Frank Racich
(Address)

15. Filed Apr 9, 1929 T. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 7 (Month) (Day) 1929

17. I HEREBY CERTIFY, That I attended deceased from March 21, 1929, to April 7, 1929, that I last saw her alive on April 6, 1929, and that death occurred, on the date stated above, at 4:45 a.m.

THE CAUSE OF DEATH* was as follows: Encephalitis Lethargica

(duration) yrs. several mos. ds.

CONTRIBUTORY (Secondary) Influenza Myocarditis

(duration) several mos. ds.

18. Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Dr. Neil Wilson M.D.
4/9, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal	Date of Burial
Greenwood Cemetery	Apr 9 1929
20. Undertaker	Address
M C Thardie	Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66330

PLACE OF DEATH

County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1911
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 33

2. FULL NAME Carolina S. Gentry

(a) Residence. No. Mullan Road, Near Wallace St.
(Usual place of abode)

74 a
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Edward Gentry.

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 51 | Months 8 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rice Lake Wisc.

PARENTS
10 NAME OF FATHER James Soderline
11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden
12 MAIDEN NAME OF MOTHER Norden
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Edward Gentry
(Address) Wallace, Idaho.

15 Filed Apr 8, 1929 H. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 5 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 1928, to Apr 5, 1929
that I last saw her alive on Apr 4, 1929
and that death occurred, on the date stated above, at 2 A m.
The CAUSE OF DEATH* was as follows:
Hemorrhage of brain.
(duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis of Para lysis [illegible] left
(duration) 1½ yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? None
What test confirmed diagnosis?
(Signed) Dr S. Lowery M. D.
1/5, 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Wallace, Idaho
Date of Burial: April 8 1929

20. Undertaker: J. A. Bever Ward Undertaking Co.
Address: Wallace, Idaho.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66331

PLACE OF DEATH

County of Shoshone
City of Wallace

CERTIFICATE OF DEATH

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 32

2. FULL NAME Carl Newman

(a) Residence. No. Wallace Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

70

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept 15 1864

7 AGE: Years 64 ~~58~~ | Months 6 | Days 19 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Colorado

PARENTS
10 NAME OF FATHER: Edward B. Newnam
11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland
12 MAIDEN NAME OF MOTHER: Sarah F. Weswall
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ill.

14 Informant: William E. Newnam
(Address) Collinsville Illinois

15 Filed Apr 1, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 4 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1929 to Apr 4, 1929
that I last saw him alive on Apr 4, 1929
and that death occurred, on the date stated above, at 9:15 a.m.
The CAUSE OF DEATH* was as follows: Encephalitis Lethargica, Endocarditis
(duration) yrs. few mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. several mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) D. A. Mottery M. D.
4/8, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: United Cemetery Wallace Ida.
Date of Burial: April 9 1929

20. Undertaker: Worstell Co. J. G. Shaughnessy
Address: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66332

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

(No. Providence Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 31

2. FULL NAME Orville Duval Jones

(a) Residence. No. 218 Cedar Street St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella A Jones

6 DATE OF BIRTH (month, day and year): Aug 23 1862

7 AGE: Years 66 | Months 7 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Clothing Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10 NAME OF FATHER: James R. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kentucky

12 MAIDEN NAME OF MOTHER: Mary Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Indiana

14 Informant: Mrs Ella .A.Jones
(Address) Wallace Idaho

15 Filed Apr 6, 1929 D. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 3 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to Apr 3, 1929, that I last saw him alive on Apr 2, 1929, and that death occurred, on the date stated above, at 7.30A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Paralysis of Bowels
Locomotor Ataxia (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. L. Quigley, M. D.

4/5/29, 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Wallace United Cemetery

Date of Burial: 4/6 1929

20. Undertaker: J. P. Shaughnissy Worstell Co.

Address: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66333

PLACE OF DEATH

County of Shoshone
City of Wallace

CERTIFICATE OF DEATH

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 30

2. FULL NAME Micheal Grady

(a) Residence. No. Wallace Idaho St. 286
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1851

7 AGE: Years 78; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Providenc Hospital

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS
10 NAME OF FATHER: Not Known
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Sister Superoir
(Address) Providence Hospital

15 Filed Apr 4, 1929 J. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Apr 6 (Month) 3 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 1928, to Apr 3, 1929, that I last saw her alive on Apr 3, 1929, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:
Myocardiles Chr
(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) old age
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Dis Moreno M. D.
4/3, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: United Cemetery
Date of Burial: 4/4/ 29 19

20 Undertaker: Worstell Co
Address: Wallace
J P Shaughnessy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66334

Local Registrar's No. 29

PLACE OF DEATH

County of Shoshone
City of Wallace
Registration District No. 20
Primary Registration District No. 1911
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Peter J. Larson

(a) Residence. No. Wallace, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day and year) 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
	66.			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10 NAME OF FATHER Not Known.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden
12 MAIDEN NAME OF MOTHER Not Known.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Carl Magnee
(Address) Wallace Idaho.

15 Filed May 4, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 1 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1929, to April 1, 1929, that I last saw h. alive on April, 1929, and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:
Myocardial degeneration
(duration) 5 yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) arteriosclerosis
(duration) 10 yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination

(Signed) [illegible], M. D.
May 2, 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho.	April 4 1929
20. Undertaker J. A. Bever Ward Undertaking Co.	Address Wallace Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A--25 M--1-19

RECEIVED JUN 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2-087
File No. 66335
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: May (Month) 27 (Day) 29 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Burke, Idaho

10. NAME OF FATHER N. C. Brockendorf

11. BIRTHPLACE OF FATHER (State or Country) Fort Collins, Colo

12. MAIDEN NAME OF MOTHER Lela Hazelberger

13. BIRTHPLACE OF MOTHER (State or Country) Burke, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs R. J. Brockendorf
(Address) Burke, Ida.

15. Filed May 31 1929 J. W. Murdock Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2 hours after birth to 27 May 1929
that I last saw h.im alive on 27 May 1929,
and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
Premature birth - lived 2 hrs.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. MacMannus M. D.
19 ..... (Address) Burke, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burke, Ida	May 28, 1929
20. UNDERTAKER L. D. Johnson	ADDRESS Burke Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-

RECEIVED JUN 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 66336
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke.
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Adelia Brietaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Apr. (Month) 18 (Day) 1855 (Year)

7. AGE: 74 Yrs. 1 Mos. 9 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burke - Idaho

10. NAME OF FATHER: Walker Brown

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Emma Miller

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Brown Brietaw
(Address) Burke, Idaho

15. Filed June 1 1929 J. F. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1929 to 5-27-1929 that I last saw h[er] alive on 5-27 1929 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart
(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Spasmodic Asthma
(Duration) 8 yrs. mos. ds.

(Signed) Ko Jennings M. D.
5/31/1929 (Address) Burke Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burke Ida — DATE OF BURIAL: 5/31/29

20. UNDERTAKER: L. D. Johnson — ADDRESS: Burke Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. RECEIVED JUN 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 66337
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Lester Bowers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Nov. 21 1877 (Month) (Day) (Year)

7. AGE: 51 Yrs. 6 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrical Work (Lineman)
(b) General nature of industry, business or establishment in which employed (or employer): Idaho Power Co

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Merrick J. Bowers

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Sadia Ann Lewis

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Gladys E. Bowers
(Address) Ontario, Ore

15. Filed 5-25 1929 J. W. Woodley Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

196

16. DATE OF DEATH: May 24 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1929, to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Electrocution

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Woodley M. D.

5-25 1929 (Address) Burke, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Nampa, Ida. DATE OF BURIAL ..... 19.....

20. UNDERTAKER: L. D. Johnson ADDRESS Burke, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66338

PLACE OF DEATH
County of Twin Falls
City of Burke

Registration District No. 39
Primary Registration District No. 2087
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mina Deane Chisham

(a) Residence. No. 9 Burke St.
(Usual place of abode)
Length of residence in city or town where death occurred. 3 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 7th 1926

7. AGE: Years 3 | Months 4 | Days 12 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Burke Ida
(State or country)

PARENTS

10. NAME OF FATHER Wm M. Chisham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Ina Morris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Wm. M. Chisham
(Address) Burke Idaho

15. Filed May 11, 1929 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17, 1929, to May 19, 1929
that I last saw her alive on May 19, 1929
and that death occurred, on the date stated above, at 1:15 P m.
The CAUSE OF DEATH* was as follows:
Bronchio-pneumonia and whooping cough
(duration) yrs. mos. 14 ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) E. L. Burns, M. D.
May 20, 1929 (Address) Burke

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burke, Ida. Date of Burial: 5/20 1929
20. Undertaker: J. Johnson Address: Burke Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66339

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Rudolf Edward Meyer 100 a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 29 1929

7. AGE Years Months 3 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buhl

PARENTS
10. NAME OF FATHER Ernest Meyer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Clara Ludwig
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Ernest Meyer
(Address) Buhl Idaho

15. Filed May 27, 1929. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-15, 1929, to 5-17, 1929
that I last saw him alive on 5-17, 1929
and that death occurred, on the date stated above, at 12:15 a.m.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Ro. Jennings, M. D.
5-17, 1929 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Clover Cemetery
Date of Burial 5/19 1929

20. Undertaker Merville D. Rigg
Address Buhl Ida

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUN 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 66340
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Churchfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~single~~ (Write the word.)

6. DATE OF BIRTH: May 1 1929 (Month) (Day) (Year)

7. AGE: 30 minutes
Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jno. R. Churchfield

11. BIRTHPLACE OF FATHER (State or Country): Truxton, Neb.

12. MAIDEN NAME OF MOTHER: Laura Duval

13. BIRTHPLACE OF MOTHER (State or Country): Wells, Nev.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Churchfield
(Address): Buhl Ida.

15. Filed May 7 1929
J. H. Murphy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 1 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to 9.30 P.M. May 1 1929
that I last saw h[illegible] alive on 9.30 P.M. " 1 1929
and that death occurred on the date stated above, at 9.30 P.M.
The CAUSE OF DEATH* was as follows:
Premature between 6 & 7 mo. caused by mother falling the previous day
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. W. Mac Manus M. D.
19..... (Address) Buhl, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetary. DATE OF BURIAL: 5-2-1929

20. UNDERTAKER: Hall ADDRESS

RECEIVED JUN 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66341

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 391

Primary Registration District No. 2081

Local Registrar's No.

(No. Twin Falls County General Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Betty Jean Reese

(a) Residence. No. 4 St. Castleford Idaho. 100 a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) ✓

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	2	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Castleford Ida

PARENTS

10. NAME OF FATHER Walter Reese

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Port Matilda Pa

12. MAIDEN NAME OF MOTHER Marie Myers

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Julian Pa.

14. Informant Walter Reese
(Address) Castleford Ida

15. Filed May 17, 1929. J. F. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 19, 1929, to Apr 23, 1929
that I last saw her alive on Apr 23, 1929
and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) P. L. Berry M. D.

4-24, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Buhl Ida — Date of Burial: Apr 24 1929

20. Undertaker: L. J. Johnson — Address: Buhl.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66342

Registration District No. 36
Primary Registration District No.
Local Registrar's No. 7

PLACE OF DEATH
County of Twin Falls
City of Hansen
(No.) (If death occurred in a hospital or institution, give its name instead of street and number)

RECEIVED JUN 3 1929

2. FULL NAME Chas E. Smith Jr.
(a) Residence. No. Hansen Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	20 Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hansen Idaho

PARENTS
10. NAME OF FATHER Chas E. Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark.
12. MAIDEN NAME OF MOTHER Etta Ray
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ark

14. Informant Chas E. Smith
(Address) Hansen Idaho

15. Filed May 29, 1929 J. M. Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 22, 1929, to Apr 22, 1929, that I last saw h alive on April —, 1929, and that death occurred, on the date stated above, at 8 PM

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. M. Davis M. D.
May 29, 1929 (Address) Kimberly, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Apr 23 1929
20. Undertaker	Address
P. J. Grossman	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66343

Registration District No. 36
Primary Registration District No.
Local Registrar's No. 6

PLACE OF DEATH
County of Twin Falls
City of Kimberly
(No. 1 Advance)
(If death occurred in a hospital or institution, give its name instead of street and number)

RECEIVED JUN 8 1929

2. FULL NAME Malissa F. Weaver

(a) Residence. No. Kimberly Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 3 1841

7. AGE 87 Years 9 Months Days 25 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER David Walk.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ga
12. MAIDEN NAME OF MOTHER Mary Digby
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ga.

14. Informant W. D. Herndon
(Address) Kimberly Ida.

15. Filed May 29, 1929 J. M. Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1929 to May 28 1929
that I last saw h alive on May 28 1929
and that death occurred, on the date stated above, at 11:30 A m.
The CAUSE OF DEATH* was as follows:
Chronic Cardio Vascular disease
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J. M. Davis, M. D.
May 29, 1929 (Address) Kimberly Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Windsor Mo.	
20. Undertaker C. J. Grossman	Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66344

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 36
Primary Registration District No.
(No. 188)
Local Registrar's No. 5

RECEIVED JUN 3 1929

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edith Percilla Tracy

(a) Residence. No. St. Ogden Utah.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Dec. 4, 1912

7. AGE: Years 16 | Months 5 | Days 1 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Yost Utah

PARENTS

10. NAME OF FATHER: William E Tracy
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Mary Holden
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Jack Smith
(Address): Burley Ida.

15. Filed May 8, 1929 J M Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 5, 1929
that I last saw her alive on May 5, 1929
and that death occurred, on the date stated above, at 10:30 A m.
The CAUSE OF DEATH* was as follows:
Automobile accident
Fracture Rt. pelvis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Cerebral Embolism
6 hrs.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Murtaugh Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J M Davis M. D.
May 8, 1929 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Yost Utah	May 9 1929
20. Undertaker	Address
R. E. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66345

PLACE OF DEATH
County of Twin Falls
City of Hansen

Registration District No. 36
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

1000

RECEIVED JUN 3 1929

2. FULL NAME Mable Ida Sherwood

(a) Residence. No. Hansen (Usual place of abode) Idaho St. (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 3-1927

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	8	1	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho, Twin Falls

PARENTS

10. NAME OF FATHER Chas L. Sherwood

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Franklin Co Indiana

12. MAIDEN NAME OF MOTHER Stella M. Abrams

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Franklin Co Indiana

14. Informant Chas L Sherwood
(Address) Hansen Ida

15. Filed May 5 1929 J M Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) - 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-28, 1929, to 5-4, 1929
that I last saw h alive on 5-4, 1929
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J M Davis, M. D.
May 5 1929 (Address) Kimberly Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida	5-7 1929
20. Undertaker	Address
White Mortuary	Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1929

PLACE OF DEATH

County of Jun Falls

City of Jun Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 2085

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 66346

Local Registrar's No.

161 B

2. FULL NAME Bobbie Lee Durham

(a) Residence. No. Rout 1 T Falls St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER W L Durham

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo

12. MAIDEN NAME OF MOTHER Iva Semler

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Colo.

14. Informant W L Durham
(Address) Jun Falls Rout 1

15. Filed 6-10, 1929 H N Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 am
May (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to May 30, 1929
that I last saw him alive on May 30, 1929
and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:
Birth Trauma
Respiratory failure
Forceps delivery
(duration) yrs. mos. 20 min ds.

CONTRIBUTORY (Secondary) Occiput Posterior Position
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John W Loughlin M. D.
5-31, 1929 (Address) Jun Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jun Falls — Date of Burial: May 31 1929

20. Undertaker: F E Drake — Address: Jun Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1929

PLACE OF DEATH

County of Twin Falls

City of " "

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66347

Registration District No. 3

Primary Registration District No.

Local Registrar's No.

(No. Co. Gen Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred D. Wegener

(a) Residence. No. Kimberly Road Twin Falls

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

117

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 15 1870

7. AGE Years 58 Months 7 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rancher &

(b) General nature of industry, business, or establishment in which employed (or employer) Tourist Park proprietor

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Fred H. Wegener

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Dorthe Bodar

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs. F. D. Wegener

(Address) Twin Falls Ida

15. Filed 6-10, 1929 H. N. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw him alive on May 20th, 1929

and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Appendicitis Recurrent. Appendectomy followed by Paresis of Bowels - (3 days)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis Chronic Interstitial

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of May 17th 29

Was there an autopsy? No

What test confirmed diagnosis? Xray & Microscopical

(Signed) Duncan L. Alexander, M. D.

5-22, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls

Date of Burial 5/24 1929

20. Undertaker P. J. Grossman

Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 10 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

DO NOT WRITE IN THIS SPACE

State File No. 66348

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Coughlin 7-A

2. FULL NAME Nellie B. Glenn

(a) Residence. No. 157 Alexander St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Fred W. Glenn

6. DATE OF BIRTH (month, day and year) Nov. 19-1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	5	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spokane County Wash.

PARENTS

10. NAME OF FATHER George Anderson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. J. H. Navin

(Address) 157 - Alexander St.

15. Filed 6-10, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 17th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 1929 to May 17th 1929

that I last saw her alive on May 17th 1929

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) Julia M. Coughlin, M. D.

5-17, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	5-20 1929

20. Undertaker White Mortuary

Address Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66349

PLACE OF DEATH
County of Twin Falls,
City of Twin Falls,
Registration District No.
Primary Registration District No.
Local Registrar's No.

(No. 207, 6th. Ave, East, Twin Falls, Ida.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Ellen J. O'Rouke

(a) Residence. No. 207 - 6th Ave, East, St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

88 W

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed,

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 5th 1850

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	3	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wis.

PARENTS

10. NAME OF FATHER George Fletcher,
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Isiebelle Riggs,
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know.

14. Informant Geo, Fletcher,
(Address) 207. 6th Ave East, Twin Falls,

15. Filed 6-10, 19 29 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May. 16 Th 29
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 19 29, to May 16, 19 29
that I last saw h alive on May 16th, 19 29
and that death occurred, on the date stated above, at 545 PM.

The CAUSE OF DEATH* was as follows:
Valvular heart disease
Cardinoma of Sigmoid
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Angina Pectoris
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) John H Crossman M. D.
5-18, 19 29 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Boise Idaho. Date of Burial May 20Th, 19 29
20. Undertaker P.J. Grossman, Address Twin Falls, d

[redacted] CEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66350

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 5
Primary Registration District No. 5
Local Registrar's No.
(No. Curley Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1. FULL NAME Harold Himler
(a) Residence. No. Twinberly St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

2. SEX [illegible]
3. COLOR OR RACE White
4. Single, Married, Widowed, or Divorced (write the word) Married
(If married, widowed, or divorced)
(HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day and year) July 13 1909

7. AGE: Years 19 | Months 9 | Days 2 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER Bert E Himler
11. BIRTHPLACE OF FATHER (city or town) Iowa
(State or Country)
12. MAIDEN NAME OF MOTHER Nora Ogle
13. BIRTHPLACE OF MOTHER (city or town) Iowa
(State or Country)

14. Informant J Himler
(Address) Bovmont Idaho

15. Filed Jun 10, 1929 F L Teets Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11-30
May (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to May 15, 1929
that I last saw h[illegible] alive on May 14, 1929
and that death occurred, on the date stated above, at 11:30 P m.
The CAUSE OF DEATH* was as follows:
Cerebral Spinal Meningitis (Epidemic form)
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & Final
(Signed) J M Davis, M. D.
May 16, 1929 (Address) J M Davis

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery — Date of Burial: May 16 1929
20. Undertaker F E Drake — Address Twin Falls

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD
N. B.—Every item of information should be [illegible] should state CAUSE OF DEATH in plain terms. Exact statement of OCCUPATION is very important. See instruction on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66351

Registration District No. 37

Primary Registration District No. [illegible]

Local Registrar's No.

(No. ~~Minnie N.~~)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minnie N. McNeis.

(a) Residence. No. 653 - 3rd Ave W. St. 49

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Oscar McNeis

6. DATE OF BIRTH (month, day and year) Oct 29-1878

7. AGE 51 Years 7 Months 14 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cedar Springs Mo

PARENTS

10. NAME OF FATHER J. T. Eslinger

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cedar Springs Mo

12. MAIDEN NAME OF MOTHER Viola Parent

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Oscar McNeis

(Address) 653 - 3rd Ave. W.

15. Filed 6-10, 1929 H. N. Leeds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 15th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1929, to May 15, 1929

that I last saw her alive on May 15, 1929

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

General Carcinoma

several years.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 1926 Aug 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emma C. Crossland DO M. D.

May 16, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Cemetery

Date of Burial May 17- 1929

20. Undertaker White Mortuary Inc

Address Twin Falls, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66352

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No. 37
Primary Registration District No. 128
(No. St. Louis)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Herman C Sutmiller
(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 3 1844

7. AGE	Years	Months	Days	If LESS than 1 day,
	84	7	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Rudolph Sutmiller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Dorothea
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs Herbert Smith
(Address) 5 Ave East Twin Falls

15. Filed Jan 10, 1929 H M Steele Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — — —, 19—, to — — —, 19—
that I last saw h— alive on — — —, 19—
and that death occurred, on the date stated above, at 9 m.
The CAUSE OF DEATH* was as follows:

Chronic Myocardiac Insufficiency
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Probable Cerebral Hemmage
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unattended
Did an operation precede death? — Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. E. Drake Coroner, M. D.
, 19 (Address) Twin Falls,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	May 15 1929
20. Undertaker J. Grossman	Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66353

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Orlando Brown County Hospital 179
(a) Residence. No. Eden County St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 23 / 1904

7. AGE: 24 Years | Months: 10 | Days: 20 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10. NAME OF FATHER: Granville Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Lelle M. Brossfield
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Granville Brown
(Address) Eden Idaho

15. Filed 6-10, 1929 H. N. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8th, 1929, to May 13th, 1929, that I last saw him alive on May 15th, 1929 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Burns - Chest abdomen Left arm fore arm hand - Right hand - Electric High tension (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Gangrene and infection (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? Hazelton Idaho
Did an operation precede death? Yes Date of 5/13/29
Was there an autopsy? No
What test confirmed diagnosis? Laboratory & Operation
(Signed) Duncan L. Alexander, M. D.
5/14/29, 19.... (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery | Date of Burial: May 15 1929

20. Undertaker: F. E. Drake | Address: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66355

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No.
(No. S W on Ranch)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Max Smith
(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Smith

6. DATE OF BIRTH (month, day and year) Apr 12 1873

7. AGE Years	Months	Days	If LESS than 1 day,
56	—	26	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ky

PARENTS
10. NAME OF FATHER Chas Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky
12. MAIDEN NAME OF MOTHER Van Roper
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Marguerite Smith
(Address) Twin Falls Ida

15. Filed 6-10, 1929 H. M. Lee Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 — 1919 to May 8 1929
that I last saw h— alive on May 8 1929
and that death occurred, on the date stated above, at 1:20 P m.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Colorado
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H Worden, M. D.
May 10, 1929 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	May 11 1929
20. Undertaker	Address
F E Drake	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66356

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 20 75
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

1618

2. FULL NAME Baby Grayheal

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): June 3 1929

7. AGE: — Years — Months — Days — If LESS than 1 day, 20 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) .....

PARENTS

10. NAME OF FATHER: Walter Grayheal
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kent
12. MAIDEN NAME OF MOTHER: Vesta Bice
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn

14. Informant: Walter Grayheal
(Address): Castleford Idaho

15. Filed 6-10, 1929 H N Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 3, 1929
that I last saw h..... alive on ....., 19..
and that death occurred, on the date stated above, at 1:40 a m.
The CAUSE OF DEATH* was as follows:
Asphyxia Neanotorum

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) A. A. Newberry M. D.
6/3, 1929 (Address) Filer Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Buhl Cemetery Co
Date of Burial: June 4 1929

20. Undertaker: Merville D Rigg
Address: Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66357

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 1
(No. 175)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jessie Clelland

(a) Residence. No. ..... St. Jerome Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of J. N. Clelland

6. DATE OF BIRTH (month, day and year) 11-20-1875

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
53	6	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home work
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER Osburg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant J. N. Clelland
(Address) Jerome

15. Filed 6-10, 1929 H. N. Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to June 4, 1929
that I last saw h[illegible] alive on June 4, 1929
and that death occurred, on the date stated above, at 12 15 P m.
The CAUSE OF DEATH* was as follows:
Romaine Pneumonia
5 hours
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? None
(Signed) John F. Churchill Jr., M. D.
June 4, 1929 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Jerome Ida	6-6 1929
20. Undertaker White Mortuary	Address Twin Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66358

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Coughlin 57

2. FULL NAME Letitia Jane Savage

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry F. Savage

6. DATE OF BIRTH (month, day and year) Nov. 16

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	6	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper at
(b) General nature of industry, business, or establishment in which employed (or employer) County Hospital
(c) Name of employer

9. BIRTHPLACE (city or town) Louris
(State or country) Canada

PARENTS

10. NAME OF FATHER Alexander Paquette
11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)
12. MAIDEN NAME OF MOTHER Victoria Chevrier
13. BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14. Informant Mary Andriano
(Address) Weston West Virginia

15. Filed 6-10, 1929 A. M. Leete
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 5th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1920, to June 5th 1929
that I last saw h er alive on June 4th, 1929
and that death occurred, on the date stated above, at 7 p. m.
The CAUSE OF DEATH* was as follows:
Diabetes Coma
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Valvular heart disease
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John W. Coughlin M. D.
6-7, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	6-8 1929
20. Undertaker	Address
White Mortuary	Twin Falls Ida

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66359

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charzella Lovras Smith

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 18 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Conrad Smith

6. DATE OF BIRTH (month, day and year) April 28 1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	61	1	8	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Jefferson
(State or country) Iowa

PARENTS

10. NAME OF FATHER David Patrick

11. BIRTHPLACE OF FATHER (city or town) Pickaway
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Nancy Jane Bruner

13. BIRTHPLACE OF MOTHER (city or town) Bruner Town
(State or Country) Indiana

14. Informant .....
(Address) Conrad Smith

15. Filed 6-10, 1929 H M Lee
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to June 3, 1929
that I last saw her alive on June 3, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Erysipelas
(duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary) Tonsilitis and myocarditis
(duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) C. D. Weaver M. D.
6/7, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	June 7 1929

20. Undertaker J E Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

MAY 16 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley

City of Cascade

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 15

(No. , St.)

File No. 66360

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew J. Mitchell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 16 (Day) 1873 (Year)

7. AGE: 55 Yrs. 6 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Hotel Proprietor

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Peoria Ill

10. NAME OF FATHER: Andrew A Mitchell

11. BIRTHPLACE OF FATHER (State or Country): Exerter Ing

12. MAIDEN NAME OF MOTHER: Margaret Miller

13. BIRTHPLACE OF MOTHER (State or Country): Potts Town Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florence Mitchell

(Address)

15. Filed ..... 19 ..... Stella Cain, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1929, to April 17 1929, that I last saw him alive on April 17 1929, and that death occurred on the date stated above, at 11:45 a.M.

The CAUSE OF DEATH* was as follows: Carcinoma of pancreas

(Duration) 0 Yrs. 6 mos. 0 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Roscoe C Ward M. D.

4/18 1929 (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cascade Idaho

DATE OF BURIAL: April [illegible] 1929

20. UNDERTAKER: Wm McBratney A.D.P.

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED MAY 16 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66361

Registered No.

1. PLACE OF DEATH

County of Valley

City of Cascade

Registration District No.

Primary Registration District No. 15

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Marion Haskins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Feb (Month) 26 (Day) 1854 (Year)

7. AGE: 75 Yrs. 1 Mos. 11 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Bela Haskins

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Margaret Elizabeth Driskell

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jay R Haskins

(Address) Cascade Ida

15. Filed 19

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6 1929 to April 8 1929 that I last saw h. alive on April 8 1929 and that death occurred on the date stated above, at 3:25 P.M.

The CAUSE OF DEATH* was as follows:

Right cerebral hemorrhage

(Duration) 0 Yrs. 0 mos. 1 ds.

Contributory (Secondary) Chronic nephritis

(Duration) 2 yrs. 0 mos. 0 ds.

(Signed) Forrest E Ward M. D.

4/9 1929 (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Brown Cem. Cascade — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66362

PLACE OF DEATH
County of Ada.
City of Boise

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 36

(No. 5th & Orchard Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Theodore W. Kuehl

(a) Residence. No. 5th & Orchard Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 28th 1902

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	8	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Wilhelm Kuehl
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Alwene Thies.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Hugo Kuehl.
(Address) Boise, Idaho.

15. Filed 6/9, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 7th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ ~~, to~~ ~~, 19~~ ~~that I last saw him alive on~~ ~~, 19~~ ~~and that~~ death occurred, on the date stated above, at 2 P.M. m.

The CAUSE OF DEATH* was as follows:
The Jury find that the deceased came to his death by means of the effects of drinking home brew beer. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) The above is the Coroner's Jury verdict. Inquest held 6/8/29 (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of —
Was there an autopsy? Stomach Examined by State Chemist
What test confirmed diagnosis?
(Signed) Wm McBratney — Coroner, M.D.
6/8/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	6/9/29. 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

RECEIVED JUN 17 1929

66363

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66363

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. St Maries Hosp)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15

185

2. FULL NAME Thomas Nixon

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE Years 48 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer) Logging
(c) Name of employer J. J. O'Neil, St Joe, Ida.

9. BIRTHPLACE (city or town) (State or country) not known

PARENTS
10. NAME OF FATHER not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) not known
12. MAIDEN NAME OF MOTHER not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) not known

14. Informant St Maries Hospital Records
(Address) by Dr C A Robins

15. Filed May 27, 1929 O Meeuwagr Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22, 1929, to May 23, 1929
that I last saw him alive on May 23, 1929
and that death occurred, on the date stated above, at 1:50 P. m.
The CAUSE OF DEATH* was as follows:
Traumatic rupture jejunum logging accident, log striking him in abdomen
..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Peritonitis
subsequent to accident (duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death? Camp near St Joe, Ida
Did an operation precede death? Yes Date of 5/23/29
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) C A Robins, M. D.
5/25, 1929 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Woodlawn
Date of Burial May 28 1929

20. Undertaker Mitchell & Meeuwagr
Address St Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 12 1929

PLACE OF DEATH

County of Ada

City of Meridian

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

66364

DO NOT WRITE IN THIS SPACE

State File No. 66364

Registration District No.

Primary Registration District No.

Local Registrar's No. 7

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

88 l

2. FULL NAME Allen Jones

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 8 - 1842

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
86	6	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mount Vernon, Ind

PARENTS

10. NAME OF FATHER: Mr Jones -

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Sarah West

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: Bertha Rinker

(Address) Nampa Idaho

15. Filed 6/11, 1929 H F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-30, 1929, to 5-31, 1929

that I last saw him alive on 5-30, 1929

and that death occurred, on the date stated above, at 5:50 A- m.

The CAUSE OF DEATH* was as follows:

myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H F Neal, M. D.

6-12, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohler Lawn Nampa

Date of Burial: June 2 1929

20. Undertaker: W. J. Mateer

Address: Meridian

66365

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66365

PLACE OF DEATH
County of Ramas
City of Fairfield Ida

Registration District No. 5B
Primary Registration District No. 2138
(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 15

2. FULL NAME Hester Stinton

(a) Residence. No. St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: English
5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Wife of Henry Stinton

6 DATE OF BIRTH (month, day and year) Mar. 9-1854

7 AGE: Years 72 ~~55~~ Months 1 Days
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Wooffertoft, Eng.

PARENTS
10 NAME OF FATHER: Dont Know
11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know
12 MAIDEN NAME OF MOTHER: Hester Maund
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: Alfred Stinton
(Address) 620 Seneca St Seattle Wash.

15 Filed Apr 10, 1929 Mrs Pearl L. Perkins
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 9 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1929, to April 9, 1929, that I last saw her alive on April 8, 1929, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows: Loss of Compensation of heart

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Valvular disease & Hypertrophy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) A. J. Shelts, M. D.
4/10, 1929 (Address) Fairfield Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Fairfield, Ida
Date of Burial: Apr 10 1929

20. Undertaker: None.
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 17 1929

STATE OF IDAHO 86366
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State File No. 66366

Local Registrar's No. 53

1. PLACE OF DEATH

County of Shoshone

Registration District No. 70

Primary Registration District No. 1011

City of Mullan

(No. Morning Mine (Mullan Ida.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Jasper Brownlow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH: Feb (Month) 15 (Day) 1896 (Year)

7. AGE: 33 Yrs. 2 Mos. 18 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer): Federal Mining & Smeltering Morning Mine, Mullan Ida.

9. BIRTHPLACE (State or Country): Helena Montana

10. NAME OF Father: George R. Brownlow

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah Mithhelson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. G. Brownlow
(Address) Mullan Idaho

15. Filed May 4 1929 F. R. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 19__, to ____ 19__, that I last saw him alive on ____ 19__, and that death occurred on the date stated above, at 5:00 P. M.
The CAUSE OF DEATH* was as follows:
Suffocation
(Duration) ____ yrs. ____ mos. ____ ds.
Contributory (Secondary) Coal Mine Accident
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) C. O. Mowery M. D.
5/4 1929 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Missoula Montana — DATE OF BURIAL 19__

20. UNDERTAKER: Worstell Co — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

66367

Form V. S. No. 5 20M-1-16-12 RECEIVED JUN 21 1929 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66367

Registered No.

1. PLACE OF DEATH.

Registration District No. 15

County of Jerome

Primary Registration District No.

City of Jerome (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lunard A Mcdonnell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Apr (Month) 7 (Day) 1899 (Year)

7. AGE: 29 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: dont Know
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF FATHER: Joseph R Mcdonnell

11. BIRTHPLACE OF FATHER (State or Country): Alabama

12. MAIDEN NAME OF MOTHER: Mary L Donaldson

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Tindie L Mcdonnell
(Address): Jerome

15.
Filed 5/25 1929 Chas F Zeller Jr. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

31

16. DATE OF DEATH: May (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1929, to May 23 1929 that I last saw him alive on May 20 1929 and that death occurred on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 3 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John F Schnackel M. D.

May 25 1929 (Address) Jerome

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery — DATE OF BURIAL: May 24 1929

20. UNDERTAKER: D A Harrison — ADDRESS: Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66328

Registration District No. 8
Primary Registration District No. 3004
Local Registrar's No. 45

PLACE OF DEATH

County of Ada.
City of Boise.
(No. Cottonwood Creek, on Government Reservation.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vernon E. Smith

(a) Residence. No. 515 N. 15th Street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

M D R

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mildred Smith.

6. DATE OF BIRTH (month, day and year) Sept. 1st 1899

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	10	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Adj. Generals Office.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grand Junction, Colo.

PARENTS

10. NAME OF FATHER S. G. Smith.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pittsburg, Iowa.
12. MAIDEN NAME OF MOTHER Mary E. Barger.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Fairfield, Iowa.

14. Informant S. G. Smith.
(Address) Caldwell, Idaho.

15. Filed 6/29, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH About June 25th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ to ~~, 19~~
~~that I last saw him alive on , 19~~
~~And that~~ death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Suicide. Shot himself in head with 32-20 Revolver. Left a note saying he was going to take his own life.
(duration) yrs. mos.
CONTRIBUTORY (Secondary) Had been dead about 48 hours when found.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No inquest held.
Did an operation precede death? Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Wm. McBratney - Coroner, M. D.
6/28/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill, Caldwell	6/29/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

RECEIVED JUN 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

66369

DO NOT WRITE IN THIS SPACE
State File No. 66369

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 49

(No.) 183
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Beryl Edward Sprague

(a) Residence. No. RT 2 D#4 Caldwell Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 29 - 1908

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	5	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ranching
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Wallace Co.
(State or country) Kansas

PARENTS

10. NAME OF FATHER C E. Sprague

11. BIRTHPLACE OF FATHER (city or town) Mahaska Co.
(State or Country) Iowas

12. MAIDEN NAME OF MOTHER Georgia Rominger

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Ill

14. Informant C E Sprague
(Address) Caldwell Ida RT 2 D#4

15. Filed 6-9-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Gun shot wound of the head.
Accidental. No inquest.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) , M. D.
June 8-29, 19 (Address) Coroner Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	June 9 1929
20. Undertaker	Address
Deckham	Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

66370

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66370

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 40

(No. U. S. Veterans' Hosp Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME James M. PHILLIPI

(a) Residence. No. Soldiers' Home, Boise, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) 4-9-1847

7. AGE	Years	Months	Days	If LESS than 1 day,
	82	2	6	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant M. Cornelius,

(Address) U. S. Veterans' Bureau, Boise, Idaho

15. Filed 6/17, 1929 W. M. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2, 1929, to June 15, 1929
that I last saw him alive on June 15, 1929,
and that death occurred, on the date stated above, at 12:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation. Chronic Myocarditis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) F. B. Brewer, Reg. Med. Officer M. D.

19 (Address) U. S. V. Bureau Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	6-17-29 19
20. Undertaker	Address
McBratney & Co.	Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

66371

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66371

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2nd
Local Registrar's No. 32

(No. U. S. Veterans' Hospital, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ernest R. CLAYPOOL

(a) Residence. No. Kansas City, Mo. St. Kansas City, Mo.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. xx yrs xx mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6. DATE OF BIRTH (month, day and year) 8-17-1895

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	9	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer xx

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS
10. NAME OF FATHER xx
11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx
12. MAIDEN NAME OF MOTHER xx
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant M. Cornelius
(Address) U. S. Veterans' Bureau, Boise, Idaho

15. Filed 6/11, 1929 W. W. Knowles Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1929, to June 10, 1929
that I last saw him alive on June 10, 1929
and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:
Meningitis, cerebral, Syphilitic
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute parenchymatous, Nephriti
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? Yes
What test confirmed diagnosis?

(Signed) F. B. Brewer, M. D.
19 (Address) Reg. Med. Officer U.S.Vet.Bureau, Boise, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kansas City, Mo.	Shipped 19 6/11/29
20. Undertaker Wm. McBratney.	Address Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

66372

DO NOT WRITE IN THIS SPACE

State File No. 66372

Registration District No. 39

Primary Registration District No. 2087

Local Registrar's No.

PLACE OF DEATH

County of Twin Falls

City of Burley

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nelson C. Abbott. 90

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Davis Abbott

6. DATE OF BIRTH (month, day and year): July 12 1893

7. AGE — Years: 36 — Months: — Days: 2 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Salesman on
(b) General nature of industry, business, or establishment in which employed (or employer): Road.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10. NAME OF FATHER: Dave Knauf

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Dave Knauf

12. MAIDEN NAME OF MOTHER: Dave Knauf

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dave Knauf

14. Informant: Mrs Davis Abbott
(Address): Indianapolis Ind

15. Filed 7-5, 1929. J. V. Murdock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-3, 1929, to 7-3, 1929, that I last saw him alive on 7-3, 1929, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows: Heart Block.

(duration) few minutes yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo Jennings, M. D.

7-4, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Indianapolis — Date of Burial 19

20. Undertaker: L. L. Johnson — Address: Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

66373

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66373

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital, 92)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 166

2. FULL NAME Charles E. Hiffard

(a) Residence. No. ..... St. Cascade Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Carrie Hiffard

6. DATE OF BIRTH (month, day and year) July 31 - 1871

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	10	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Saw Mill
(b) General nature of industry, business, or establishment in which employed (or employer) Superintendant.
(c) Name of employer Hallock-Howard Co

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Carrie Hiffard
(Address) Cascade Idaho

15. Filed 6/14, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1929, to June 14, 1929
that I last saw h[illegible] alive on June 14, 1929
and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:
Thrombosis of Mesenteric
Veins, Gangren Bowels
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Blow in abdomen
3 or 4 wks ago (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Cascade
Did an operation precede death? Yes Date of 6-12-29
Was there an autopsy? Yes
What test confirmed diagnosis? Operation

(Signed) Surgeon, M. D.
6/14, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Coeur D'Alene Idg Date of Burial June 18 - 1929

20. Undertaker Summers & Krebs Address Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

66374

DO NOT WRITE IN THIS SPACE

State File No. 66374

PLACE OF DEATH

County of Benewah

City of St Maries

Registration District No. 3

Primary Registration District No. 2049

Local Registrar's No. 16

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

140

2. FULL NAME Casper Marty

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Pearl Marty

6. DATE OF BIRTH (month, day and year) Aug 4 - 1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	10	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) mill work

(c) Name of employer St Maries Mill Co

9. BIRTHPLACE (city or town) (State or country) Engi Switzerland

PARENTS

10. NAME OF FATHER Antone Marty

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Engi Switzerland

12. MAIDEN NAME OF MOTHER Pearl Mean

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Engi Switzerland

14. Informant Mrs. Levi Hill

(Address) St Maries Ida

15. Filed June 18 1929 O Clemenger Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30, 1929 to , 19

that I last saw him alive on May 30, 1929

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Accidently smothered in sawdust bins of St Maries Mill Co

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? was necessary

What test confirmed diagnosis?

(Signed) O Clemenger Coroner M. D.

June 18, 1929 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Woodlawn	June 3 1929

20. Undertaker	Address
Mitchell & Menager	St Maries Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Braddock

RECEIVED JUL 5 1929

66375

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66375

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

131

2. FULL NAME Rev August Stemper
(a) Residence. No. Clarkston Wash St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Aug 29 - 1853

7. AGE Years 76 Months 8 Days 26 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Minister Catholic Church
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER Stemper
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs J Becker
(Address) Nez Perce Idaho

15. Filed June 8, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1929, to May 25, 1929
that I last saw him alive on May 25, 1929
and that death occurred, on the date stated above, at 10 80 P m.
The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous nephritis (duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Clarkston Wash
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Urinalysis
(Signed) E G Braddock, M. D.
May 27, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Uniontown Wn
Date of Burial 19

20. Undertaker Vassars
Address Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-[illegible] RECEIVED JUN 29 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2136

(No. ..... St.)

State File No. 66376 66376

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leslie L. Fox.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Not Known. (Month) (Day) 1 (Year)

7. AGE: 40 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Railroad Engineer
(b) General nature of industry, business or establishment in which employed (or employer): O.S.L. Railroad

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF Father: Not Known.

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Alice Fox

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Fox
(Address) 803 East Clark, Pocatello, Idaho

15. Filed 6-27 1929 H. H. King Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19, 1929 to June 20 1929, that I last saw him alive on June 20 1929, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Auto Injury

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. Ashley M. D.

6-20 1929 (Address) Montpelier

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oelwien, Iowa

DATE OF BURIAL: June 25 1929

20. UNDERTAKER: F. M. Williams

ADDRESS: Montpelier, Idaho.

[illegible] of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66377

PLACE OF DEATH

County of ADA

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 42

(No. U. S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alvin James LAWRENCE

(a) Residence. No. Smithfield, Utah St. Smithfield, Utah
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. xx yrs xx mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. Alvin Lawrence

6. DATE OF BIRTH (month, day and year) 9-2-1891

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	37	9	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Utah
(State or country)

PARENTS

10. NAME OF FATHER xx Colm

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) xx
(State or Country)

14. Informant M. Cornelius

(Address) U.S.Vet. Bureau, Boise, Idaho

15. Filed 6/25, 19 29 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 24 (Day) 19 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 19 29, to June 24, 1929, 19
that I last saw him alive on June 24, 1929, 19
and that death occurred, on the date stated above, at 12:55 P.M.

The CAUSE OF DEATH* was as follows:

Pyelo Nephritis. Cystitis ulcerative.

(duration) yrs. mos. ds.

CONTRIBUTORY none
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy confirmed diagnosis

(Signed) E.H.Cooper, Act.Reg.Med.Off., M. D.

, 19 (Address) U.S.V.B.Boise,Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Smithfield, Utah	19
20. Undertaker McBratney & Co.	Address Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66378

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 39

PLACE OF DEATH

County of Ada.
City of Boise.
(No. Collister Station.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William B. Cole

(a) Residence. No. Collister Station. St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth Cole

6. DATE OF BIRTH (month, day and year) March 24th 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	2	14	------

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Railroad man.

(b) General nature of industry, business, or establishment in which employed (or employer) Section Foreman.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan.

PARENTS

10. NAME OF FATHER Wm. B. Cole.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada.

12. MAIDEN NAME OF MOTHER Don't Know.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. Elizabeth Cole.
(Address) Boise, Idaho.

15. Filed 6/14, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 8th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to June 8, 1929
that I last saw h[illegible] alive on June 8, 1929
and that death occurred, on the date stated above, at 11 P.M. m.
The CAUSE OF DEATH* was as follows:
Chronic nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [signature] M. D.
6-13-29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	6/10/29 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 6 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No. U. S. Veterans' Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66379

Local Registrar's No. 35

2. FULL NAME James Brayton PIERCE

(a) Residence. No. Albion, Idaho St. Albion, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6. DATE OF BIRTH (month, day and year) 7-31-1879

7. AGE	Years	Months	Days	If LESS than 1 day,
	49	10	9	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10. NAME OF FATHER Chas. Pierce

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant

(Address)

15. Filed 6/13, 1929 W. A. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21, 1928, to June 10, 1929

that I last saw him alive on June 10, 1929

and that death occurred, on the date stated above, at 2:55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

Chronic Myocarditis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) F. B. Brewer, Reg. Med. Officer M. D.

, 19 (Address) U. S. Vet. Bureau
Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	June 13, 1929
20. Undertaker: McBratney & Co.	Address: Boise, Idaho

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66380

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 35

(No.) Irrigating Ditch, East end of Warm Springs Ave
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ellen Sadie Trammell.

(a) Residence. No. [illegible] Boise, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) Nov. 18th 1927

7. AGE Years	Months	Days	If LESS than 1 day, ---------- or ---------- min.
1	6	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Consumers, Utah.
(State or country)

PARENTS

10. NAME OF FATHER Goliath Trammell.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Texas.

12. MAIDEN NAME OF MOTHER Fay Smith.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Ark.

14. Informant Goliath Trammell.
(Address) Boise, Idaho.

15. Filed 6/15, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ---------- 19--, to ---------- 19--, that I last saw her alive on ---------- 19--, and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Accidently drowned in Irrigation ditch. Was in the water about one-half hour. No inquest Held.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. McBratney - Coroner, M. D.

5/27/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	5/28/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66381

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 34

(No. 7½ Miles Northwest of Boise.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

170

2. FULL NAME Charles Benjamin Malmstrom.

(a) Residence. No. 7½ Miles N.W. of Boise. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie Malmstrom.

6. DATE OF BIRTH (month, day and year): June 9th 1869

7. AGE: 59 Years | Months: II | Days: 20 | If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): California.

PARENTS

10. NAME OF FATHER: Charles E. Malmstrom

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Stockholm, Sweden

12. MAIDEN NAME OF MOTHER: Matilda Edwards.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sidney, Australia.

14. Informant: Fred Malmstrom.
(Address): Boise, Idaho Route #3.

15. Filed 6/5, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 29th 1929. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ----, 19--, to ----, 19--, ~~that I last saw h--- alive on~~ ----, 19--, ~~and that~~ death occurred, on the date stated above, at 6:30 AM m.

The CAUSE OF DEATH* was as follows: Suicide by shooting himself in the forehead with a 22 high power Savage Rifle. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Had been in poor health for over a year. (duration) yrs. mos. ds.

M. Inquest held.

18. Where was disease contracted if not at place of death? Had made numerous threats to take his own life.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. McBratney, Coroner, M.D.

6/1/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 6-1-1929.

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66382

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
(No.) U. S. Veterans' Hospital, Boise, Idaho
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 33

2. FULL NAME Harold C. McCool

(a) Residence. No. Emmett, Idaho St. Emmett, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. xx yrs. xx mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of xx

6. DATE OF BIRTH (month, day and year) 12-5-1893

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35	5	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant M. Cornelius
(Address) U.S.Veterans' Bureau, Boise, Idaho

15. Filed 6/4, 1929 W. T. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1929, 19..., to June 2, 1929, 19...
that I last saw him alive on June 2, 1929, 19...
and that death occurred, on the date stated above, at 7:50 P.M. m.
The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY xx
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? xx
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) F.B.Brewer, Reg. Medical Officer M. D.
..., 19... (Address) Vet. Bureau
Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Emmett Idaho	
20. Undertaker McBratney & Co.	Address Boise, Idaho

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66383

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 171
(No. St Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David W. Williams
(a) Residence. No. ..... St. Moscow Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ida May Williams
6. DATE OF BIRTH (month, day and year) April 14 1851
7. AGE 78 Years 2 Months 15 Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) ~~Kansas~~ Wales
PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown
14. Informant Mrs. J. J. Beale
(Address) Clarkston Wash.
15. Filed 6/29, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6/29 (Month) (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 6/20, 1929, to 6/27, 1929
that I last saw him alive on 6/28, 1929
and that death occurred, on the date stated above, at 5:50 A.m.
The CAUSE OF DEATH* was as follows:
Hypostatic
Pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Subacute obstruction
Ileum
(duration) yrs. mos. ds.
Entero-enterostomy
18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 6/24-29
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Ralph Falk, M. D.
6/29, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho Date of Burial July 2 1929
20. Undertaker Summers & Krebs Address Boise Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

April-14-1851.
Birthplace Wales.

Clarkston, Wash.
Jan. 27, 1930

Summers & Crebs,
Funeral directors, Boise, Ida.

Dear Sirs,

In giving you the information for the death certificate of my father D. W. Williams, I was mistaken in the place of birth as well as the date of birth. We will have to have this corrected before we can collect his life insurance, and so I am writing to you to get you to send me a correcting affidavid so that I can send it in, with my corrected affidavid, to the Insurance company.

Will you please have the death certificate changed also.

The correct date of birth is April 14, 1851 making him 78 instead of 79, as I told you. He was born in Wales and came to this country when only six months old.

Please have this attended to as quickly as you can as we are holding other papers until we hear from you.

Please let me know how much it will be to have the Death Certificate changed and the corrective affidavid made out and I will mail you a check for the ammount.

I Will appreciate this very much and thank you in advance, also for your kindness.

Yours truly

Mrs. J. J. Beale

Clarkston

R.1.B.18A. Wash.

7 8 2 - 15

1891 - 4 - 14

1929 - 6 - 29

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66385

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 169

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

R

2. FULL NAME Baby Ray.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) June 24th 1929

7. AGE Years: 0 Months: 0 Days: 0 If LESS than 1 day, 8 hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Dell Ray.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cedar Rapids, Neb.

12. MAIDEN NAME OF MOTHER Helen Potter.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Boise, Idaho.

14. Informant Mrs. D. E. Ray.

(Address) Eagle, Idaho.

15. Filed 6/25, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 24th 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...

that I last saw h..... alive on ....., 19...

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature 7 weeks was born in an auto on way to hospital, exposure

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) A. J. Coats, M. D.

6/25/29, 19... (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Star Cemetery. Date of Burial: 6/25/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66386

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. ~~117~~ 168
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Eleanor Coughlin

(a) Residence. No. 1104 Main St.
(Usual place of abode)
Length of residence in city or town where death occurred. 10 yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 17-1919

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	2	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise, Ida

PARENTS

10. NAME OF FATHER: William J. Coughlin
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Can.
12. MAIDEN NAME OF MOTHER: Florence Murphy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Oregon

14. Informant: W. J. Coughlin
(Address): Boise

15. Filed 6/22/1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13, 1929, to June 20, 1929
that I last saw h[er] alive on June 20, 1929
and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:
acute appendicitis
Post operative pneumonia
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Post Operative pneumonia
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of June 14 '29
Was there an autopsy? not.
What test confirmed diagnosis?

(Signed) J. Earl Keil, M. D.
June 22, 1929 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. John's Cemetery	6/22/1929
20. Undertaker	**Address**
Schreiber & McCann	Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66387

RECEIVED JUL 6 1929

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 167
(No.) St. Alphonsus
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elise Jannau Hollers

(a) Residence. No. 722 N. Franklin St.
(Usual place of abode)
Length of residence in city or town where death occurred. 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: German
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Hollers

6. DATE OF BIRTH (month, day and year): May 27-1840

7. AGE: 89 Years | Months | Days: 21 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10. NAME OF FATHER: John Jacob Kramp
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Anna E. Jung
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: James R Lusk
(Address): 722 Franklin St

15. Filed 6/21, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) June (Day) 18 (Year) 1929

17. I HEREBY CERTIFY, That I attended deceased from 6/17, 1929 to 6/18, 1929
that I last saw her alive on 6/18, 1929
and that death occurred, on the date stated above, at 4:30 A. m.
The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Fractured 3rd 4th 5th Cervical vertebrae
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Sanitarium
Did an operation precede death? Date of Tonsilectomy
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible], M. D.
6/21, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pioneer Cemetery	6/20 1929
20. Undertaker	Address
Schreiber & McCann	Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66389

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 164

(No. St. Alphonsus Hospital.
(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Will T. Montgomery

(a) Residence. No. Mt. Home Idaho Mt. Home Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Montgomery

6. DATE OF BIRTH (month, day and year) 5-1-1863

7. AGE 66 Years Months 1 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant & Stockman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) California

PARENTS

10. NAME OF FATHER John N. Montgomery

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Melvina Rhoda Rountree

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Walter Montgomery
(Address) Glenn Ferry Idaho.

15. Filed 6/13, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 1180 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/11, 1929, to 6/13, 1929

that I last saw ~~him~~ alive on 6/13, 1929

and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Hypostatic

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/11/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical Sy

(Signed) Fred A. Pillaugh, M. D.

6/13, 1929 (Address) Boise Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt. Home Ida. Date of Burial Shipment 6-13-29

20. Undertaker G. S. Zacher Address Mt. Home Ida

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66390

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 163

(No. 406 O'Farrell St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Valeria M. Carringer.

(a) Residence. No. 406 O'Farrell St.
(Usual place of abode)
Length of residence in city or town where death occurred. 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chester C. Carringer.

6. DATE OF BIRTH (month, day and year) Jan. 21st 1853.

7. AGE Years	Months	Days	If LESS than 1 day, ~~hrs. or~~ min.
76	4	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER Shick.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Willis H. Carringer.
(Address) Eagle, Idaho.

15. Filed 6/11, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 8th 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1929, to June 8, 1929,
that I last saw h[illegible] alive on June 7, 1929
and that death occurred, on the date stated above, at 9:30 AM m.
The CAUSE OF DEATH* was as follows:

Uremia Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. McBratney, M. D.

, 1929 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dry Creek Cemetery	6/9/29 19

20. Undertaker Wm. McBratney. Address Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JUL 6 1929

DO NOT WRITE IN THIS SPACE
State File No. 66391

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Luke's Alphonsus
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 162

2. FULL NAME Mildred Mary Harlow
(a) Residence. No. Emmett Idaho St. 58a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Caucasian
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: William Harlow

6. DATE OF BIRTH (month, day and year): Nov. 11, 1896

7. AGE: 32 Years: 32 Months: 6 Days: 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Oakley Idaho.

PARENTS

10. NAME OF FATHER: John F. Mills.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pleasant Grove Utah.
12. MAIDEN NAME OF MOTHER: Mary Argenta Tanner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Union Utah.

14. Informant: Mrs J. F. Mills
(Address)

15. Filed 6/11, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1929 to June 8, 1929
that I last saw her alive on June 8, 1929
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Pernicious Anaemia
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Lobar Pneumonia
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Emmett Ida
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Blood finding
(Signed) Jamesh Stewart M. D.
June 11, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverside Cemetary Emmett
Date of Burial: June 11, 1929

20. Undertaker: C. R. Buchman
Address: Emmett Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66392

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 161

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Major J Hall

(a) Residence. No. 431 S Thatcher St St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of Elizabeth Hall

6. DATE OF BIRTH (month, day and year) Oct 1- 1852

7. AGE	Years	Months	Days	If LESS than 1 day,
	76	8	6	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Well Driller

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Prince Eduard Isle Canada

PARENTS

10. NAME OF FATHER Jonathan Hall

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Jennie Ramsey

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Prince Eduard Isle.

14. Informant Lizzie M. Hall.

(Address) 431 S Thatcher St Boise Ida

15. Filed 6-11, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6- 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/27, 1929 to 6/8, 1929

that I last saw h[illegible] on 6/8, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diabetis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symp

(Signed) Fred. A. Pettingill M. D.

6/10, 1929 (Address) Boise Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	6-10 1929
20. Undertaker	Address
Eckreberg McCann	Boise Ida

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66393

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 160
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Russell Elmer Fry

(a) Residence. No. Eagle, Idaho Route #I. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ada Fry.

6. DATE OF BIRTH (month, day and year) March 7th 1899

7. AGE Years	Months	Days	If LESS than 1 day, ---------- hours or ---------- min.
30	3	I	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Eagle, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER George W. Fry.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Mary Robinson.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa.

14. Informant Mrs. Ada Fry.
(Address) Eagle, Idaho.

15. Filed 6/10, 1929 W. N. Rhodes.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 8th 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1929 to June 8, 1929
that I last saw him alive on June 8, 1929
and that death occurred, on the date stated above, at 6:30 A.M.
The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 21 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? His home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P.A. French, M. D.
June 10, 1929 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Star Cemetery.	6/II/29 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66394

PLACE OF DEATH RECEIVED JUL 6 1929

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 159

2. FULL NAME Della Ellen Dye

(a) Residence. No. St. Glenns Ferry Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Chris M. Dye

6. DATE OF BIRTH (month, day and year) Feb 17 - 1891

7. AGE Years 38 Months 3 Days 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lassen County California

PARENTS

10. NAME OF FATHER Joseph Lane Roberts
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown Virginia
12. MAIDEN NAME OF MOTHER Clara Ellen Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Feather River California

14. Informant Chris M. Dye
(Address) Glenns Ferry

15. Filed 6/10, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28, 1929, to Death, 19
that I last saw her alive on May 28th, 1929
and that death occurred, on the date stated above, at 4 a.m.
The CAUSE OF DEATH* was as follows:

Myocarditis with hypertension and arteriosclerosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical findings
(Signed) L. F. West, M. D.
6-6, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Glenns Ferry Idaho
Date of Burial 5-31 1929

20. Undertaker G. C. Zach Mountain Home Ida.
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66395

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 158

(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME Richard Lloyd Hudgins.

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ----------

6. DATE OF BIRTH (month, day and year): June 4th 1929

7. AGE: Years 0 | Months 0 | Days 3 | If LESS than 1 day, ---------- hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Boise, Idaho.

PARENTS

10. NAME OF FATHER: L. M. Hudgins.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Lena Wheeler.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Nebraska.

14. Informant: L. M. Hudgins.
(Address) Boise, Idaho. R. #2.

15. Filed 6/7, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 7th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to June 7, 1929 that I last saw him alive on June 6, 1929 and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows: Elderly Parents, weak spinal cells

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (Broncho) (duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. N. Braxton, M. D.
6/7/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 6/8/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66396

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 157

100a

2. FULL NAME James Peter Cooper
(a) Residence No. 1503 Broadway St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct-5-1928

7. AGE Years | Months 8 | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho

PARENTS
10. NAME OF FATHER Harry J. Cooper
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holland
12. MAIDEN NAME OF MOTHER Ada Wilton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montana

14. Informant Harry J. Cooper
(Address) 1503 Broadway St. Boise Ida

15. Filed 6/6, 1929 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 7 A.M. 1929, to ....., 19..., that I last saw him alive on June 6 7 A.M., 1929 and that death occurred, on the date stated above, at 8.30 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? physical signs
(Signed) H. M. Robinson, M. D.
June 6, 1929. (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: June 7 1929

20. Undertaker: Summers & Krebs | Address: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 6 1929

Calaway Fst Nat Bank Bldg

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66397

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 156

2. FULL NAME Valentine Amack

(a) Residence. No. ..... St. Meridian Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sep 27. 1877

7. AGE: Years 51, Months 7, Days 5. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lucerne Mo

PARENTS
10. NAME OF FATHER: E. G. Amack
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn
12. MAIDEN NAME OF MOTHER: Mary Young
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo

14. Informant: Emma Amack Meier
(Address) 1606 N. 8. Boise Idaho

15. Filed 6/5, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) — 5 (Day) — 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22, 1929, to June 5, 1929
that I last saw him alive on June 4, 1929
and that death occurred, on the date stated above, at 7:45 A m.
The CAUSE OF DEATH* was as follows:
Spotted Fever

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) ✓

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) M. Caccaway-Joplin, M. D.
June 5, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery — Date of Burial: June 6 1929

20. Undertaker: W S Mather — Address: Meridian Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66398

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 155
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oliver Carpentier

(a) Residence. No. Garden Valley, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Carrie Carpentier nee Smith

6. DATE OF BIRTH (month, day and year) Dec. 26, 1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	3	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Livestock
(b) General nature of industry, business, or establishment in which employed (or employer) Riding after livestock.
(c) Name of employer Garden Valley Cattle Association

9. BIRTHPLACE (city or town) Garden Valley
(State or country)

PARENTS

10. NAME OF FATHER Nazaire Carpentier
11. BIRTHPLACE OF FATHER (city or town) Montreal
(State or Country) Canada
12. MAIDEN NAME OF MOTHER Margaret Carle Fleet
13. BIRTHPLACE OF MOTHER (city or town) Walla Walla
(State or Country) Wn.

14. Informant Adele M. Caine
(Address) 115 W. Jefferson St. Boise Ida.

15. Filed 6/3, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 4, 1929, to Apr 13, 1929
that I last saw alive on Apr 13, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Carcinoma of Stomach
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Gumies Pass Id
Did an operation precede death? yes Date of Apr 5-29
Was there an autopsy? yes
What test confirmed diagnosis? Clinical—Surgical

(Signed) Fred A. Partridge M. D.
4/15, 1929 (Address) Boise Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	4/15 1929

20. Undertaker	Address
Schreiber & McCaw	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66399

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 154

2. FULL NAME Edna Marie Fisk
(a) Residence. No. 1 Mile W. of Eagle
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Fisk

6. DATE OF BIRTH (month, day and year) Dec 15-1895

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	5	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Yakima Wash

PARENTS

10. NAME OF FATHER Allison B. Richardson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Gertrude V. Heath
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) California

14. Informant Charles Fisk
(Address) Eagle Idaho R.D.#1

15. Filed 6/2, 1929 W. A. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
5 (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/29, 1929, to 5/30, 1929
that I last saw h[illegible] alive on 5/30, 1929
and that death occurred, on the date stated above, at 11:45 A. m.
The CAUSE OF DEATH* was as follows: Uremia (24 hrs)

(duration) 6 yrs. mos. ds.
Intercurrent Chronic Interstitial Nephritis
(Secondary) Scarlet fever
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 5/29
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) A. J. Cook M. D.
5/31, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	June 1 1929
20. Undertaker	Address
Summers & Krebs	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66400

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 153

(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred H. Skidmore

(a) Residence. No. ..... St. Pioneerville Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Feb. 1873
7. AGE: Years 56 | Months 3 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ashland Oregon

PARENTS
10. NAME OF FATHER Joseph H. Skidmore
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER Annie Hall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Joseph H. Skidmore
(Address) Susanville Oregon
15. Filed 5/31, 1929 W. H. Rhodes Registrar

611

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 30 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 26, 1929, to May 30, 1929
that I last saw him alive on May 30, 1929
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows: Rocky Mountain Spotted Fever
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? In Mountains
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P. P. French M. D.
May 31, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: June 3 1929
20. Undertaker: Summers & Trabe — Address: Boise Idaho

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66401

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 5
Primary Registration District No. 2005
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 52

2. FULL NAME Helen Mona Gluch

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 28 1911

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
17	8	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pleasant Valley Idaho

PARENTS

10. NAME OF FATHER Joseph Gluch

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Margaret Jane Clegg

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pleasant Valley Idaho

14. Informant Mrs Joseph Gluch
(Address) Jordan Valley Oregon

15. Filed 6-17- 1929 John S. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-3-29, 19, to 6-9-29, 19
that I last saw her alive on 6-9-29, 19
and that death occurred, on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) - Early Pulmonary Tuberculosis - T.B. - unble (duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? - Oregon
Did an operation precede death? no Date of
Was there an autopsy? yes.
What test confirmed diagnosis? - Autopsy
(Signed) Ernest E. Fuller M. D.
6-14- 1929. (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Jordan Valley, Ore	June 12 1929

20. Undertaker C. J. Peckham
Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66402

PLACE OF DEATH
County of Ada
City of Meridian
Registration District No. 11
Primary Registration District No. 2003
Local Registrar's No. 8
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Jefferson Alben Gilliland

(a) Residence. No. .... St. ....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah Stone Gilliland

6. DATE OF BIRTH (month, day and year) May 30 1863

7. AGE: Years 66 | Months — | Days 18 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Business Man
(b) General nature of industry, business, or establishment in which employed (or employer): Mercantile
(c) Name of employer: Owner

9. BIRTHPLACE (city or town) (State or country): Arkansas

PARENTS

10. NAME OF FATHER: Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ~~Abt Captain~~ (Alabama)
12. MAIDEN NAME OF MOTHER: Hodge
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tennessee

14. Informant: Sarah S. Gilliland
(Address): Meridian Ada

15. Filed 6-20, 1929 — H F Neal, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 17th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-26-, 1929, to 6-17, 1929
that I last saw him alive on 6-19- 1929
and that death occurred, on the date stated above, at 9:40 P. m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) 8 yrs. .... mos. .... ds.
CONTRIBUTORY (Secondary) ....
(duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? .... Date of ....
Was there an autopsy? ....
What test confirmed diagnosis? ....
(Signed) H F Neal, M. D.
6-19, 1929 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Meridian Ada — Date of Burial: 6-19 1929
20. Undertaker: B. W. Robinson — Address: Meridian Ida

FORM V. S. No. 5-25 M. 1-19

RECEIVED JUL 3 1929

66403

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada

City of Star, Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9-10

Primary Registration District No. 9-10

(No. ..... St.)

File No. 83

Registered No. 83

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dean White.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 29 (Day) 1929 (Year)

7. AGE: — Yrs. — Mos. — ds.

IF LESS than 1 day how many 6- hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ada Co. Idaho

10. NAME OF FATHER: Ed White

11. BIRTHPLACE OF FATHER (State or Country): Mame Mccalls

12. MAIDEN NAME OF MOTHER: Mrs Ed White

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Ed White

(Address) Star Idaho

15. Filed June 29 1929

Orrice Jackson
Local Registrar
Eagle Idaho

MEDICAL CERTIFICATE OF DEATH

145

16. DATE OF DEATH: June (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1929, to June 29 1929, that I last saw her alive on June 29 1929, and that death occurred on the date stated above, at 7:10 A.M.

THE CAUSE OF DEATH* was as follows:

Atelectasis.—

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Difficult Labor —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ora Hall M. D.

..... 19 ..... (Address) Star Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery

DATE OF BURIAL: 6/29 1929

20. UNDERTAKER: Sumner Kreb

ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66404

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 20-21
Local Registrar's No. 45
(No. Ada Co. Idaho City Road
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Milo Krpan

(a) Residence. No. [illegible] Boise St.
(Usual place of abode)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) About 1890

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	39			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Boise Payette Lumber Co

9. BIRTHPLACE (city or town) (State or country) Juca Slavia

PARENTS

10. NAME OF FATHER Marco Krpan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Juca Slavia
12. MAIDEN NAME OF MOTHER Maria Filka Golac
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Juca Slavia

14. Informant Martin Golac
(Address) Boise Idaho

15. Filed 6/29/29 W. F. Rhode Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Accidental - Chest crushed by a log.
Died in 3 hours (duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) none
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? ____
(Signed) W. A. Forbes M. D.
July 1, 1929 (Address) Boise

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Johns Cemetery	6/30 1929
20. Undertaker	Address
Schreiber & McCann	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66405

PLACE OF DEATH

County of Ada.

City of Meridian

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 44

(No. 1½ Miles West of Meridian, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Howard Bailey,

(a) Residence. No. Wendling, Oregon. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) March 1913

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
16			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work In School.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Junction City, Ore.

PARENTS

10. NAME OF FATHER H. E. Bailey.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Neb.

12. MAIDEN NAME OF MOTHER Roxie Howard.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Neb.

14. Informant H. E. Bailey.
(Address) Wendling, Oregon.

15. Filed 6/27, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 19th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ----------, 19--, to ----------, 19--
~~that I last saw him alive on~~ ----------, 19--
~~and that~~ death occurred, on the date stated above, at 9 A.M m.

The CAUSE OF DEATH* was as follows: Auto Accident, Accidental, Dron Auto off highway running into telephone pole. Killing Him (duration) instantly yrs. mos. ds.

CONTRIBUTORY (Secondary) No. Inquest (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ---

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm. McBratney, Coroner, ~~M. D.~~

6/20/29 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Eugene, Oregon.	19
20. Undertaker Wm. McBratney.	Address Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66406

PLACE OF DEATH

County of Ada.

City of Meridian.

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 43

(No. I½ Miles West of Meridian, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188e

2. FULL NAME Raymond Paul Bailey.

(a) Residence. No. Wendling, Oregon. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) 1915

7. AGE: Years 14 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: In School.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Junction City, Ore.

PARENTS

10. NAME OF FATHER: H. E. Bailey.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Roxie Howard.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Neb.

14. Informant: H. E. Bailey.
(Address) Wendling, Oregon.

15. Filed 6/27, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 19th 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ----------, 19---, to ----------, 19--
~~that I last saw it~~ ---- ~~alive on~~ ----------, 19--
~~and that~~ death occurred, on the date stated above, at 9 A.M. m.

The CAUSE OF DEATH* was as follows: Auto Accident - Accidental was riding in auto which ran off the highway into a telephone pole. Died in few minutes from injuries.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
No. Inquest. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ---

Was there an autopsy? No. ---

What test confirmed diagnosis? ---

(Signed) W. McBratney Coroner, ~~M. D.~~

6/20/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Eugene, Oregon. | Date of Burial 19

20. Undertaker: Wm. McBratney. | Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 6 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No. U. S. Veterans' Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66407

Local Registrar's No. 42

2. FULL NAME O'CONNOR, Charles E.

(a) Residence. No. Montpelier, Idaho St. Montpelier, Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of xx

6. DATE OF BIRTH (month, day and year) 7-26-1896

7. AGE	Years	Months	Days	If LESS than 1 day,
	32	10	28	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant M. Cornelius

(Address) U. S. Vet. Bureau, Boise, Idaho

15. Filed 6/26, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21, 19..., to June 24, 1929

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Cerebral Syphilis Meningitis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E.H.Cooper, Acting Asst. Med. Off. M. D.

..., 19... (Address) U.S. Vet. Bureau
Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello, Idaho.	19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho

FORM [illegible] M. [illegible]

RECEIVED JUN 14 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66408

Registered No. 110

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock

City of Downey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83

Primary Registration District No. 2160

(No. ..... , ... St.)

2. FULL NAME Frederick Fauteck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 25 (Day) 1845 (Year)

7. AGE: 83 Yrs. 6 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Riepenhöfen ~~Hanover~~ Province Hanover Germany

10. NAME OF FATHER: Frederick Fauteck

11. BIRTHPLACE OF FATHER (State or Country): Hanover - Germany

12. MAIDEN NAME OF MOTHER: ~~Elizabeth~~ Maria Bohn Fauteck

13. BIRTHPLACE OF MOTHER (State or Country): Hanover Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M Fauteck

(Address) Downey Idaho

15. Filed May 30 1929 Mary C. Coffin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May-22-1929, to May-27-1929 that I last saw him alive on May-22-1929 and that death occurred on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows: Adrenoma of Prostate

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Hartvigsen M.D.

5-27-1929 (Address) Downey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 15 days. In the State ..... yrs. ..... mos. 15 days

Where was disease contracted if not at place of death? .....

Former or usual residence: Colorado Springs

19. PLACE OF BURIAL OR REMOVAL: ~~[illegible]~~ Pocatello, Ida

DATE OF BURIAL: May 30 1929

20. UNDERTAKER: Hall

ADDRESS: Pocatello

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JUN 29 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bear Lake

City of Geneva

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2132

(No. ..... St.)

State File No. 66411

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter Bischoff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: Sept (Month) 15 (Day) 1913 (Year)

7. AGE: 15 Yrs. 7 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep herder
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Geneva, Idaho

10. NAME OF Father: Alfred Bischoff

11. BIRTHPLACE OF FATHER (State or Country): Montpelier, Idaho

12. MAIDEN NAME OF MOTHER: Eliza Teuscher

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alfred Bischoff
(Address) Geneva, Idaho

15. Filed 6/25 1929 H. H. King
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 1929, to ——— 19....,
that I last saw h—— alive on ——— 19....,
and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows:
Instantly killed by a flash of lightening, while heading sheep near Geneva, Idaho
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Williams ~~M. D.~~ County Coroner
June 14 1929 (Address) Montpelier, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Geneva Idaho

DATE OF BURIAL: June 15 1929

20. UNDERTAKER: F. M. Williams

ADDRESS: Montpelier, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M-1-19

RECEIVED JUN 29 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66412

Local Registrar's No.

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2132

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anthony C. Jensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ~~Female~~ Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6. DATE OF BIRTH Jan. (Month) 16 (Day) 1882 ~~1929~~ (Year)

7. AGE 47 Yrs. 5 Mos. ——— ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Railroad Brakeman

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Montpelier, Idaho

10. NAME OF Father Paul Jensen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Jens Christensen

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Jensen

(Address) Montpelier Idaho

15. Filed 6/27 1929

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1929 to June 16 1929

that I last saw h— alive on June 16 1929

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Nephritis

Neuritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Cirrhosis of Liver

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. F. Dudley M. D.

6-17 1929 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Montpelier Idaho | DATE OF BURIAL June 19 1929

20. UNDERTAKER J. H. Williams | ADDRESS Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5 A. 25M. 1-19.

RECEIVED JUN 29 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66413

Local Registrar's No.

1. PLACE OF DEATH

County of Bear Lake Registration District No. 52

City of Montpelier Primary Registration District No. 2136

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gladys Hoge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: May 16 1916 (Month) (Day) (Year)

7. AGE: 13 Yrs. 1 Mos. — ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Paris Idaho

10. NAME OF Father: George A Hoge

11. BIRTHPLACE OF FATHER (State or Country): Paris Idaho

12. MAIDEN NAME OF MOTHER: Lucy Tackrell

13. BIRTHPLACE OF MOTHER (State or Country): Randolph Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Geo A. Hoge
(Address): Paris Idaho

15. Filed 6/27/29 H H Krug Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 15 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1929 to June 15 1929, that I last saw her alive on June 15 1929 and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis
Nephritis
(Duration) ....yrs. ....mos. ....ds.
Contributory (Secondary) Influenza
(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Address) [illegible] 6-27 1929

*State the Disease Causing Death; or if deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris, Idaho
DATE OF BURIAL: June 17 1929

20. UNDERTAKER: J. M. Wilkinson
ADDRESS: Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JUN 29 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66414

Registration District No. 52

Primary Registration District No. 2136

Local Registrar's No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lena C. Stucki

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word)

6. DATE OF BIRTH: June (Month) 2. (Day) 1883 (Year)

7. AGE: 45 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF Father: Martin Funk

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Caroline Bender

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Raymond Stucki
(Address) Montpelier, Idaho

15. Filed 6/29/ 1929 N. W. King Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1927 to May 22 1929, that I last saw h[illegible] alive on May 22 1929, and that death occurred on the date stated above, at 3 M.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Operation

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. C. Bailey M. D.

5-24 1929 (Address) Montpelier

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris Idaho — DATE OF BURIAL: May 25 1929

20. UNDERTAKER: H. H. Williams — ADDRESS: Montpelier, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A 25M 1-19

RECEIVED JUN 29 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66415

Local Registrar's No.

1. PLACE OF DEATH
County of Bear Lake
City of Ovid
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136
(No.) (St.)

2. FULL NAME Mabel Johnson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Jan. (Month) 30 (Day) 1903 (Year)

7. AGE: 26 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ovid Idaho

10. NAME OF Father: Chris Sorenson.

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Lena Samuelson.

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Sorensen
(Address) Grace Bear Lake

15. Filed 6/27/29 N. N. Kemp Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-20 1929 to 4-27 1929, that I last saw her alive on 4-25 1929, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH was as follows*:
Neglected Throat
(Streptococcic Infection)
Streptococcus Viridans
(Duration) ....yrs. ....mos. ....ds.
Contributory (Secondary) Septicemia
(Duration) ....yrs. ....mos. ....ds.

(Signed) L. V. Cauley M. D.
(Address) Montpelier
4/27/29

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ovid Idaho | DATE OF BURIAL: 4/29 1929

20. UNDERTAKER: J. W. Clem | ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A-25M-1-19

RECEIVED JUN 29 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2136

(No. ..... St.)

State File No. 66416

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sylvia Skinner 74a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Jan (Month) 27 (Day) 1859 (Year)

7. AGE: 70 Yrs. 2 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Bugham City Utah

10. NAME OF Father: Stephen Delsay

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Lydia Snyder

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A. Skinner

(Address) Nounan

15. Filed 6/25 1929 H H King Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1929, to April 21 1929, that I last saw her alive on April 21 1929, and that death occurred on the date stated above, at 1:41 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Galphin M. D.

Apr 22 1929 (Address) Montpelier Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nounan Idaho

DATE OF BURIAL: April 25 1929

20. UNDERTAKER: [illegible]

ADDRESS: Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19

RECEIVED JUN 29 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 52

Primary Registration District No. 2136

(No. ..... St.)

State File No. 66417

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George W. Henderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Aug (Month) 28 (Day) 1856 (Year)

7. AGE: 72 Yrs. 7 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ~~Ohio~~ Carpenter
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF Father: Wm Henderson

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Geo W. Henderson
(Address) Montpelier, Idaho

15. Filed 6/27 1929 H. H. King
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 1929, to Apr 15th 1929, that I last saw him alive on Apr 12th 1929, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Hypostatic Pneumonia
Hypostatic Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. F. Guyon M. D.

Apr 14 1929 (Address) Montpelier Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho
DATE OF BURIAL: Apr 15 1929

20. UNDERTAKER: J. H. Williams
ADDRESS: Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 29 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66418

PLACE OF DEATH
County of Bear Lake
City of Geneva

Registration District No. 51
Primary Registration District No. N36
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Lester Hirschi

(a) Residence. No. Geneva Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months 11 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Geneva Ida

PARENTS

10. NAME OF FATHER: Raynold Hirschi
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Lun Switzerland
12. MAIDEN NAME OF MOTHER: Lucia Messerly
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Matinwell Switzerland

14. Informant: Raynold Hirschi
(Address): Geneva - Idaho

15. Filed 6/25, 1929 H H King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25, 1929, to 4-22, 1929
that I last saw her alive on April 6, 1929
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Pneumonia
Pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Inglemyer
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature], M. D.
4-23, 1929 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Geneva Idaho | Date of Burial: 4/25 1929

20. Undertaker: Bishop Teuscher | Address: Geneva Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 29 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66419

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

101B

2. FULL NAME Joseph Grady
(a) Residence. No. Stanton, Nebraska St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) July 1-1902
7. AGE 26 Years 9 Months 3 Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerical
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Omaha Nebr
PARENTS
10. NAME OF FATHER Dan Grady
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Omaha Nebr
12. MAIDEN NAME OF MOTHER ~~Blattberry~~ Katherine Brady
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Olathe Kansas Nebr
14. Informant Thos L. Brady
(Address) Stanton Nebr.
15. Filed 6/25, 1929 H. H. King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 4 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 4-1, 1929, to 4-4, 1929
that I last saw her alive on 4-4, 1929
and that death occurred, on the date stated above, at 10 24 m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Influenza
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Geo F. Lickley, M. D.
4-6, 1929 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Omaha Nebr
Date of Burial Apr. 6 1929
20. Undertaker H. W. Williams
Address Montpelier Idaho

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JUN 29 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bear Lake

City of Georgetown

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2136

(No. ..... St.)

State File No. 66420

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louise Aschlinian 1183

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH: Apr (Month) 1 (Day) 1863 (Year)

7. AGE: 65 Yrs. ..... Mos. 11 ds. 19

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF Father: Henry Bagi

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Dan Seymour

(Address) Georgetown Idaho

15. Filed 6/25/ 1929 H. H. Kenz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 1 1929, to Mar 19 1929, that I last saw her alive on Mar 17 1929, and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Intestinal Tumor

Intestinal Tumor

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Russel Tigert M. D.

Mar 20 1929 (Address) Soda Springs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho

DATE OF BURIAL: Mar 22 1929

20. UNDERTAKER: [illegible]

ADDRESS: Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. [illegible] 85M-1-19

RECEIVED JUN 29 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66421

Local Registrar's No.

1. PLACE OF DEATH
County of Bear Lake
City of Bennington
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5-2
Primary Registration District No. 2736
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Richard Holmes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Nov. 1 (Month) (Day) 1911 (Year)

7. AGE: 13 Yrs. 4 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montpelier Idaho

10. NAME OF Father: Oliver W. Holmes

11. BIRTHPLACE OF FATHER (State or Country): Montpelier, Idaho

12. MAIDEN NAME OF MOTHER: Isabelle Hall

13. BIRTHPLACE OF MOTHER (State or Country): Bennington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Elmer W. Holmes
(Address): Bennington Idaho

15. Filed 6/27 1929 N. N. Kemp Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. 30 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw h... alive on ..... 19...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Killed by accidental discharge of 22 rifle held in hands of deceased Shot through a door (Chevrolet). Purely accidental.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M.D.
1929 (Address) Montpelier Idaho

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bennington — DATE OF BURIAL: Apr. 2 1929
20. UNDERTAKER: [illegible] — ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 29 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66422

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 736
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Anna C. Keitch
(a) Residence. No. Montpelier Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

133

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of C P Keitch
6. DATE OF BIRTH (month, day and year) Sept 7 1886
7. AGE Years 43 Months 5 Days 23 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hew Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) New York
PARENTS
10. NAME OF FATHER Yons Gregesson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Anna K Jensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark
14. Informant Chas C Keitch
(Address) Montpelier Idaho
15. Filed 6/27, 1929 H H King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 2 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to March, 1929
that I last saw her alive on March, 1929
and that death occurred, on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Rupture Gall Bladder
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Gall Stones
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Leo J. Oestley, M. D.
Jun 3, 1929 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wardboro Idaho
Date of Burial Jan 5 1929
20. Undertaker [illegible]
Address Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5—20M—10-12 RECEIVED JUN 29 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2136

(No. ..... St.)

File No. 66423

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Betty Rose Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 29th 1928 (Month) (Day) (Year)

7. AGE: ..... yrs. 8 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Georgetown, Idaho

10. NAME OF FATHER: Harold T. Anderson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah Buhler

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harold T. Anderson

(Address) Georgetown Ida

15. Filed 3/24 1929 H. N. King Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 24th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 21st 1929, to Mar 24 1929, that I last saw her alive on Mar 24 1929 and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:

Septic Infection
(Following abscess of Breast)

..... (Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. N. King M. D.

3/24 1929 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Georgetown Ida

DATE OF BURIAL: 3/26 1929

20. UNDERTAKER: Mrs Hess

ADDRESS: Georgetown Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 29 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66424

PLACE OF DEATH
County of Bear Lake
City of Geneva Idaho

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

101 B

2. FULL NAME Grant W. Marx
(a) Residence. No. Geneva Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) ~~Feb~~ Jan 27 1929

7. AGE — Years — Months 1 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Geneva Idaho

PARENTS
10. NAME OF FATHER Wm A Marx
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Hulda Widmer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montpelier Ida

14. Informant Wm A Marx
(Address) Geneva Idaho

15. Filed 6/27, 1929 H H King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Had No Physician 19 ..... 19 ..... that I last saw h ..... alive on ..... 19 ..... and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Pneumonia
Short Time
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Geneva Ida
Did an operation precede death? — Date of —
Was there an autopsy? No
What test confirmed diagnosis? Dont Know
(Signed) E. F. Guyon, M. D.
Mch 3, 1929 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Geneva Idaho
Date of Burial Mch 6th 1929

20. Undertaker Bishop Tenney Stone
Address Geneva Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 29 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66425

PLACE OF DEATH
County of Bear Lake
City of Montpelier Ida

Registration District No. 52
Primary Registration District No. 2136

Local Registrar's No. 2136

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

143

2. FULL NAME Mrs Freda B. Taylor
(a) Residence. No. — Montpelier Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 24 yrs. — mos. 6 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6. DATE OF BIRTH (month, day and year) Feby 13, 1905

7. AGE

Years	Months	Days	If LESS than 1 day,
24	—	6	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): — — —
(c) Name of employer: — — —

9. BIRTHPLACE (city or town) (State or country): Montpelier Ida

PARENTS

10. NAME OF FATHER: Sam Berger
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Switzerland
12. MAIDEN NAME OF MOTHER: Margaret Gerber
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Switzerland

14. Informant: Peter Berger
(Address): Montpelier Idaho

15. Filed 2/24, 1929 — S. H. Hung, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1929, to Feby 19", 1929
that I last saw her alive on Feby 19, 1929
and that death occurred, on the date stated above, at 8, P. m.
The CAUSE OF DEATH* was as follows: Post Puerperal Mania followed by Coma x Pregnancy x
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed ~~diagnosis~~? Clinical Symptoms
(Signed) E. F. Guyon, M. D.
Feby 20th, 1929 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Montpelier Ida — Date of Burial: Feb 21 1929

20. Undertaker: F. M. Williams — Address: Montpelier Ida

RECEIVED JUN 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66426

PLACE OF DEATH
County of Benewah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049
(No. Espe Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14

2. FULL NAME Everett J. Isaacson

(a) Residence. No. ..... St. 64
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Sept. 9 - 1900

7. AGE: Years 28, Months 8, Days 6. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Barber.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10. NAME OF FATHER: John Isaacson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Mariah Gustafson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Stevens Isaacson
(Address) Fernwood Ida

15. Filed May 15, 1929 O. Meraga, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to May 15, 1929
that I last saw him alive on May 15, 1929
and that death occurred, on the date stated above, at 3:30 a m.
The CAUSE OF DEATH* was as follows:
Acute alcoholism

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G. G. Espe, M. D.
5/15/29, 19.... (Address) St Maries Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emida Ida
Date of Burial: May 17 1929

20. Undertaker: Mitchell & Meraga
Address: St Maries Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 6 1929

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Benewah State Idaho Registered No. 10
Township ..... or Village Defmet 66427 or
City Defmet No. ....., ... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Fred J. Levi

(a) Residence. No. ..... St., ... Ward. 74a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: W
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Ellis Widowed

6 DATE OF BIRTH (month, day, and year): April 26 1867

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
62	1	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS
10 NAME OF FATHER: Thomas Levi
11 BIRTHPLACE OF FATHER (city or town) (State or country): Canada
12 MAIDEN NAME OF MOTHER: Elizabeth Negent 6/17
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Canada

14 Informant: Colman Levi
(Address) Tekoa Wash.

15 Filed June 18, 1929 John Post REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1929

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1929, to June 16, 1929, that I last saw him alive on June 16, 1929, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. A. Nelson, M. D.
6/17, 1929 (Address) Tekoa Wash

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Catholic Cemetery Tekoa
DATE OF BURIAL: June 19 1929

20 UNDERTAKER: C. L. Schuberud
ADDRESS: Tekoa Wash

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 6 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66428

PLACE OF DEATH
County of Bonneville
City of De Smet
Registration District No. 31
Primary Registration District No. (No.)
Local Registrar's No. 11

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Charles A. Gimble

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) January 14, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	58	5	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Americus, Kansas

PARENTS

10 NAME OF FATHER Philip Gimble

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Laddy A. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio U. S.

14 Informant G. E. Gimble
(Address) De Smet, Idaho

15 Filed June 22, 1929 John Post Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 20 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____, that I last saw h____ alive on ____, 19____, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:
No Medical Attendance.
Heart Failure (Probable)
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) No Medical Attendance M. D.
____, 19____ (Address) Sudden death

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Fairfield, Wash. — Date of Burial: June 22 1929

20. Undertaker: C. L. Schmerend — Address: Tokoa, Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 8 1929

PLACE OF DEATH

County of Bennah

City of St Maries

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66429

Local Registrar's No. 18

88B

2. FULL NAME George Stager

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, ~~or Divorced (write the word)~~: married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6. DATE OF BIRTH (month, day and year)

7. AGE: About 53 Years; Months: ?; Days: ; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: cook

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: Midway Cafe

9. BIRTHPLACE (city or town) (State or country): not known

PARENTS

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): not known

14. Informant: Midway Cafe

(Address): St Maries Ida

15. Filed July 2, 1929 O. Meager Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to —, 19..., that I last saw him ~~alive~~ dead on June 29, 1929 and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH* was as follows:

Myocarditis (acute)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): alcoholism

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? examination

What test confirmed diagnosis? .....

(Signed) O. Meager, M. D.

July 6, 1929 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Woodlawn — Date of Burial: July 6 1929

20. Undertaker: Mitchell & Meager — Address: St Maries Ida

RECEIVED JUL 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66430

PLACE OF DEATH
County of Benwah
City of St Maries Ida
Registration District No. 32
Primary Registration District No. 2049
(No. St Maries Hosp)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

1889

2. FULL NAME Floyd Weston

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) not known

7. AGE Years 29 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer) Logging
(c) Name of employer Edw. Rutledge Timber Co

9. BIRTHPLACE (city or town) (State or country) not known

PARENTS
10. NAME OF FATHER not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) not known
12. MAIDEN NAME OF MOTHER not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) not known

14. Informant St Maries Hospital
(Address) St Maries Ida

15. Filed June 8, 1929 O S Meager Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1929, to June 6, 1929
that I last saw him alive on June 6, 1929
and that death occurred, on the date stated above, at 6:00 P m.
The CAUSE OF DEATH* was as follows: Accidental traumatism by crushing with a log Traumatic amputation left leg just below knee Hemorrhage & Shock (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death? Co 31, Clarkia, Ida
Did an operation precede death? No Date of —
Was there an autopsy? None
What test confirmed diagnosis? History Injury & Exam
(Signed) C A Robins, M. D.
6/8, 1929 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Dutton Ontario Canada | Date of Burial: on arrival

20. Undertaker: Mitchell & Meager | Address: St Maries Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED JUL 11 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bennewah.

City of Plummer Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 46

Primary Registration District No. 2123.

(No. ..... , ... St.)

File No. 66431

Registered No. 5

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fredrick James Washburn.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: July (Month) 19th (Day) 1878 (Year)

7. AGE: 50 Yrs. 10 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Telegraph Operator.

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Portage, Wisconsin.

10. NAME OF FATHER: Cyrus Washburn.

11. BIRTHPLACE OF FATHER (State or Country): Compton Canada

12. MAIDEN NAME OF MOTHER: Francis Filippin

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Harriet Wadsworth (Sister)

(Address) Plummer, Ida.

15. Filed June 12 1929 H. G. Jaeger Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Inever Saw this Man during his — 19 ..., to ..... 19 ..., that I last saw h..... alive on Illness 19 ..., and that death occurred on the date stated above, at 7:15 A. M.

The CAUSE OF DEATH* was as follows:

Heart Leakage.

..... (Duration) — Yrs. 18 mos. — ds.

Contributory (Secondary) Heart Block

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) J. L. Huntington M. D.

..... 19 ..... (Address) Norley, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portage Wisc

DATE OF BURIAL: June 17 1929

20. UNDERTAKER: Shipping H. G. Jaeger

ADDRESS: Plummer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66432

PLACE OF DEATH
County of Bingham
City of Springfield

Registration District No. 116
Primary Registration District No. 2195
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

2. FULL NAME Arthur Gale Chandler
(a) Residence. No. Springfield, Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 20. 1928

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
1	4	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot, Ida

PARENTS

10. NAME OF FATHER Henry V. Chandler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Dorothy Snyder
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Mrs. H. V. Chandler
(Address) Springfield, Ida.

15. Filed 6/23, 1929 McMarkinson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Drowning
Accidental
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) McMarkinson M. D.
June 22 1929 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Springfield
Date of Burial: 6/23 1929

20. Undertaker: Friends
Address: Springfield

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66433

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 122

(No. SOUTH IDAHO INSANE ASYLUM)

(If death occurred in a hospital or institution, give its name instead of street and number.)

14a

2. FULL NAME JAMES ANDREW GAULT

(a) Residence. No. ..... St. Unknown
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE

4. COLOR OR RACE: WHITE

5. Single, Married, Widowed, or Divorced (write the word): Unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years: About 78 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ---

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ---

PARENTS

10. NAME OF FATHER ---

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ---

12. MAIDEN NAME OF MOTHER ---

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ---

14. Informant Grace A Clippinger R.N.
(Address) Blackfoot, Idaho

15. Filed June 27, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 27th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1928, 19, to June 27th 1929, 19

that I last saw him alive on June 27th 1929, 19

and that death occurred, on the date stated above, at 6:55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Two days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? None

(Signed) Geo Williams, M. D.

June 28th 1929, 19 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Asylum Cemetary | Date of Burial: 6-29-29 19

20. Undertaker: Claren C. E. Byerly. | Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66434

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 121

2. FULL NAME Andrew Quitman Gibson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sep 6th 1849

7. AGE: Years 79, Months 9, Days 19. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kendle Penn

PARENTS

10. NAME OF FATHER: Joseph Gibson
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Laura Rebecca Conkle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Hooks Town Penn

14. Informant: Flora B. Hopkins
(Address) Blackfoot Idaho

15. Filed June 25 1929 McWater E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to June 25, 1929
that I last saw him alive on June 25, 1929
and that death occurred, on the date stated above, at 2 A. m.
The CAUSE OF DEATH* was as follows:
Cancer of throat
..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) F. Mitchell M. D.
6/25, 1929 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Green City Cemetery
Date of Burial: June 28 1929

20. Undertaker: E. F. Peck
Address: Blackfoot

FORM V. S. No. 5-25 M. 1-19. JUL 5 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ..... St.)

State File No. 66435

Local Registrar's No. 120

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wray Vern Webb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: March (Month) 16 (Day) 1929 (Year)

7. AGE: — Yrs. 3 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Lehi Utah

10. NAME OF Father: Vern W. Webb

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Effie Wray

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Vern W. Webb
(Address) 477 No. 2 West, Lehi, Utah

15. Filed June 16 1929 Mrs Walter E. Potter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1929. to June 16 1929, that I last saw him alive on June 14 1929, and that death occurred on the date stated above, at 7:20 A.M.

The CAUSE OF DEATH* was as follows:

Microcephalus

(Duration) — yrs. 3 mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.

6/16 1929 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lehi Utah

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: E J Peck

ADDRESS: Blackfoot Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66436

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 131
Primary Registration District No. 2194
(No. South Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 119

76

2. FULL NAME LUCY J EGGLESTON

(a) Residence. No. ..... St. BOISE IDAHO
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 8 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 72 Years | Months: 5 | Days: 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lowell, Ill.

PARENTS

10. NAME OF FATHER: A.E. Blair-
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Grace A. Clippinger Nurse
(Address) Blackfoot, Idaho

15. Filed June 17, 1929 Mr. Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 15th, 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 3rd, 1928, 19..., to June 15th 1929, 19...
that I last saw her alive on June 15th, 1929, 19...
and that death occurred, on the date stated above, at 11:40 A m.
The CAUSE OF DEATH* was as follows:

Paralysis of Insane

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ——

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo. Williams M. D.
June 15th, 1929 (Address) Blackfoot, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Boise Idaho | Date of Burial: 19

20. Undertaker: E J Peck | Address: Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66437

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194

Local Registrar's No. 118

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Zelma Cornia

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 15, 1929

7. AGE

Years	Months	Days	If LESS than 1 day,
			hrs. or 30 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Blackfoot
(State or country) Ida

PARENTS

10. NAME OF FATHER John McCornia
11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)
12. MAIDEN NAME OF MOTHER Kathryn Cameron
13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)

14. Informant J. M. Cornia
(Address) Blackfoot, Idaho Rt. 2

15. Filed June 15, 1929 W. McCaleb Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to June 15, 1929
that I last saw h[illegible] alive on June 15, 1929
and that death occurred, on the date stated above, at 11:[illegible]0 a m.
The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos. 30 Min

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. McCaleb, M. D.
June 15, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Groveland Cem. | Date of Burial 19

20. Undertaker | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66438

PLACE OF DEATH

County of Bingham
City of Blackfoot.

Registration District No. 121
Primary Registration District No. 2144
Local Registrar's No. 117

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Allen Crawford.

(a) Residence. No. Blackfoot. Rt. 4 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth C. Crawford

6. DATE OF BIRTH (month, day and year) July, 11, 1883.

7. AGE Years	Months	Days	If LESS than 1 day,
85	11	27	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER James B. Crawford
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Rebbeca Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Elizabeth C. Crawford
(Address) Blackfoot. Ida. Rt. 4.

15. Filed June 16, 1929 Walter E. Votaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June. 14. 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1929, to June 14, 1929
that I last saw him alive on June 13, 1929
and that death occurred, on the date stated above, at 3:00 a. m.
The CAUSE OF DEATH* was as follows:

Apoplexy
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis
(duration) 5 yrs. 0r mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W W Beck, M. D.
June. 15. 1929 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Thomas-Riverside Cem.	Jun. 16. 1929
20. Undertaker	Address
Modenn Mortuary.	Blackfoot. Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66439

PLACE OF DEATH

County of Bingham
City of Blackfoot.
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Weiber

(a) Residence. No. ½ Mile N.E. Groveland St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eva Weiber

6. DATE OF BIRTH (month, day and year) May. 19, 1844.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85	0	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS

10. NAME OF FATHER Conrad Weiber.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Anna Elizabeth Cox
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant T. H. Peters T. H. Peters.
(Address) Blackfoot, Ida, Rt. 4

15. Filed June. 13 19 29 McCaleb E. Tabor Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June. 12. 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to June 12, 1929
that I last saw h.. im alive on June 11, 1929, 19..
and that death occurred, on the date stated above, at 1:30 A m.
The CAUSE OF DEATH* was as follows:

Cancer of the Liver

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) L. D. Hamilton, M. D.
June 12, 1929 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls. Ida	June14,29 19

20. Undertaker	Address
Modern Mortuary	Blackfoot Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66440

PLACE OF DEATH
County of Bonneville
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 115

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Christian Hanson

(a) Residence. No. Ground St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) November 26 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	67	6	12	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER James C Hanson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Lena Hanson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Robert Hansen
(Address) Blackfoot Ida Route 1

15. Filed June 10, 1929 McCalister Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 8, 1929
that I last saw her alive on June 8, 1929
and that death occurred, on the date stated above, at 11.00 m.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
(duration) yrs. mos. 1 ds.
CONTRIBUTORY Arteriosclerosis
(Secondary)
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) F. McMaster, M. D.
June 9, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Groveland Cemetery	June 10 1929
20. Undertaker E J Peck	Address Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25-M. 1-10

RECEIVED JUL 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Woodville

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ..... St.)

File No. 66441

Registered No. 114

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Jean Hancock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 29 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Babe

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Woodville Idaho.

10. NAME OF FATHER: Elgia Leroy Hancock

11. BIRTHPLACE OF FATHER (State or Country): Richfield Utah

12. MAIDEN NAME OF MOTHER: Lovena Neroby.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elgia Leroy Hancock

(Address) R. 4. Idaho Falls

15. Filed June 5 1929 Mrs Walter E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 5 (Day) 1919 (Year)

161a

17. I HEREBY CERTIFY, That I attended deceased from 6-2 1929, to 6-5-1929 that I last saw her alive on 6-5-1929 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows: Premature birth (8 months gestation) Digestive Complications.

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Infantile Convulsions.

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Edwin Cutler M. D.

6-5-1929 (Address) Shelley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? at home.

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodville Cemetery

DATE OF BURIAL: 6-5-1929

20. UNDERTAKER: None

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66442

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 113

44

2. FULL NAME Thomas Heber Findlay

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Findlay

6. DATE OF BIRTH (month, day and year): July 26, 1861

7. AGE: Years 67 | Months 10 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Layton, Utah

PARENTS

10. NAME OF FATHER: Thomas Findlay
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Ann Watson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: T M Findlay
(Address): Blackfoot City

15. Filed: June 7, 1929 McCalvin E. Patrick, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from: I saw him in consultation
that I last saw him alive on May 1, 1929
and that death occurred, on the date stated above, at 4:30 a m.
The CAUSE OF DEATH* was as follows:
Attending physician not obtainable
Cancer of Stomach
(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Feb 4 1929
Was there an autopsy? no
What test confirmed diagnosis? Observed at operation
(Signed) W W Beck, M. D.
June 5, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery — Date of Burial: June 8 1929

20. Undertaker: E T Peck — Address: Blackfoot

RECEIVED JUL 5 1929

STATE OF IDAHO Current- Complete May 29
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66443

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ft. Hall Reservation, Idaho.

City of

Registration District No. 121-R

Primary Registration District No. 2194-R

Local Registrar's No. 112

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Parazevah.

(a) Residence. No. /------ St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Tovonap

6. DATE OF BIRTH (month, day and year): 1871

7. AGE: Years 58, Months -, Days -, If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Brigham City, Utah

PARENTS

10. NAME OF FATHER: Sam Vitch

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mus-so-gup

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Henry Chabean
(Address) Ft. Hall, Idaho.

15. Filed June 16, 1929 Mrs Walter E Palmer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 15, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to May 15, 19

that I last saw her alive on May 15, 1929, 19

and that death occurred, on the date stated above, at 5:P m.

The CAUSE OF DEATH* was as follows:

Nephritis,-Chronic.

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) ---

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ----

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry R. Wheeler, M. D.

, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ft. Hall Reservation, May 15, 1929 19

Date of Burial

20. Undertaker: Shoemaker & Beasley, Pocatello Idaho.

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

current complete May 1929

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66444

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ft. Hall Reservation
City of Idaho.

Registration District No. I2I R
Primary Registration District No. 2I94 R

Local Registrar's No. 111

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Tomoyo Johnson.

(a) Residence. No. -- St. ----
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Shoshone Ind. 4/4
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: TailJJohnson

6. DATE OF BIRTH (month, day and year): I880

7. AGE: Years 49 | Months -- | Days -- | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Spencer, Montana

PARENTS

10. NAME OF FATHER: Big Ox.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Com-en-dit-it-se.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs. Alex Woods.
(Address) Ft. Hall, Idaho.

15. Filed Ma June, 19 I6, I929 Mrs Walter E Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 9, I929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May I, 19 29, to May 9, I, 19
that I last saw him alive on May 9, I929, 19
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Tuberculoses of the Lungs

(duration) I yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ----
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Henry R. Wheeler, M.D.
, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ft. Hall Reservation, May I2, I929 | Date of Burial 19

20. Undertaker: Brown Eldredge, Blackfoot, Ida. | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

current complete May 1929

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66445

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ft. Hall Reservation Idaho.

City of

Registration District No. I2I R.

Primary Registration District No. 2 I94 R

Local Registrar's No. 110

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ivan Antelope.

(a) Residence. No. ---- St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

11a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6. DATE OF BIRTH (month, day and year) Dec. I5, I928

7. AGE Years | Months 4 | Days 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft. Hall Reservation

PARENTS

10. NAME OF FATHER Antelope

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nevada

12. MAIDEN NAME OF MOTHER Lucy Shay

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ft. Hall Reservation

14. Informant Lucy Antelope
(Address) Ft. Hall, Idaho

15. Filed June I6, 19 29 Mrs Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May I2, I929
No Doctor Attending (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at II:P.M m.

The CAUSE OF DEATH* was as follows:

Flu.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? ---

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry R. Wheeler M. D.

, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ft. Hall Reservation, Date of Burial: May I4, I 19

20. Undertaker: Shoemaker & Beasley, Pocatello Idaho Address

current complete May 1929

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66446

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation Idaho

City of

Registration District No. I2I R.

Primary Registration District No. 2I94- R.

Local Registrar's No. 109

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

3

2. FULL NAME Tom Broncho

(a) Residence. No. --- St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6. DATE OF BIRTH (month, day and year) Sept. 26, I9I9

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
9	8	--	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft. Hall Reservation

PARENTS

10. NAME OF FATHER Timothy Broncho

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ft. Hall Reservation

12. MAIDEN NAME OF MOTHER Evylin Summer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ft. Hall Reservation

14. Informant Evelyn Broncho

(Address) Ft. Hall, Idaho

15. Filed June I6, 19 29 Mrs Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26, I929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2, 19 29, to May 26, 19

that I last saw him alive on May 26, I929, 19

and that death occurred, on the date stated above, at 2: P m.

The CAUSE OF DEATH* was as follows:

Tuberculoses of the Lungs

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Tubercular Perotonit is

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? --

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Henry R. Wheeler M.D.

, 19 (Address) Ft. Hall, Id a

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ft. Hall Reservation, May

Date of Burial: 3I, I929 19

20. Undertaker: Shoemaker & Beasley, Pocatell o

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

current complete May 1929

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66447

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft.Hall Reservation
City of Idaho

Registration District No. I2I- R
Primary Registration District No. 2I94- R

Local Registrar's No. 108

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Dan.

(a) Residence. No. --- St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Shoshone Ind. 4/4
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) I9II

7. AGE: Years I8 | Months)) | Days -- | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home . Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nevada

PARENTS

10. NAME OF FATHER: Indian Dan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Nevada
Mattie Preacher
12. MAIDEN NAME OF MOTHER: Nevada
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Tom Preacher,
(Address) Ft.Hall, Idaho

15. Filed June I6, 1929 Mrs Walter E Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 30, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May i, 1929, 19, to May 30, 19
that I last saw him alive on May 29, 1929, 19
and that death occurred, on the date stated above, at 2: A m.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) ----
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ---
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) Henry P. Wheeler M. D.
, 19 (Address) Ft.Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ft.Hall Reservation, June 2, I 19
Date of Burial

20. Undertaker: Brown & Eldredge, Blackfoot, Id a
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66449

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 27

2. FULL NAME Baby Brummett

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): X

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 19 1929

7. AGE Years | Months | Days | If LESS than 1 day, 24 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hailey Idaho

FARENTS

10. NAME OF FATHER Raymond H Brummett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Texas
12. MAIDEN NAME OF MOTHER Mary B Silkett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant R F Brummett
(Address) Hailey Ida

15. Filed 6-30, 1929 R. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH FOX

16. DATE OF DEATH June (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/20, 1929, to 6/21, 1929
that I last saw her alive on 6/21, 1929
and that death occurred, on the date stated above, at 2-9 m.
The CAUSE OF DEATH* was as follows:
Two Premature - Inanition and some Congenital deformity of stomach not determined (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. W. Fox, M. D.
6/21, 1929 (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey Idaho | Date of Burial: June 22 1929

20. Undertaker: Harris & Amos E244 | Address: Hailey Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66450

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 26
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William A Gilliam

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 6 1883

7. AGE Years 45 Months 11 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Telephone Mgr
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Carey Telephone Co

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10. NAME OF FATHER Lilburn Gilliam
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Mary J Lyons
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant M F Gilliam
(Address) Caldwell Idaho

15. Filed 6-30, 1929 R. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

FOX

16. DATE OF DEATH June (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/14, 1929, to 6-21, 1929
that I last saw him alive on 6/21, 1929
and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:
Peritonitis following 4 day rupture of Gangrenous Pus appendix
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 6/19-29
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) E. W. Fox, M. D.
6/21, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Carey Idaho
Date of Burial June 23 1929

20. Undertaker Harris & Amos E244
Address Hailey-Ida.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66451

PLACE OF DEATH
County of Blaine
City of Bellevue

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 25

2. FULL NAME Joseph Werry

(a) Residence. (No. ..... St. .....)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 22 1841

7. AGE	Years	Months	Days	If LESS than 1 day,
	87	8	24	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Miner
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Joseph Werry -
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cornwall England
12. MAIDEN NAME OF MOTHER Grace Nicholls
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Cornwall - England

14. Informant W. G. WERRY
(Address) Bellevue Idaho.

15. Filed 6-30, 1929 T. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

Wright

16. DATE OF DEATH June (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-9, 1929, to 6-16, 1929 that I last saw h~~im~~ alive on 6-13, 1929 and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Sciatica & Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Robert H. Wright - M. D.
6-17, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bellevue Idaho	June 22 1929
20. Undertaker	**Address**
Harris & Anson	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66452

PLACE OF DEATH
County of Boise
City of Horseshoe Bend
Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martin A. Foss

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 8 - 1846

7. AGE: Years 83 | Months 4 | Days 11 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10. NAME OF FATHER: Hans Foss
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Myrna N. Foss
(Address) Gardena Idaho

15. Filed 6/20, 1929 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 19, 1929
that I last saw h[illegible] alive on June 17, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocardial weakness
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) , M. D.
6/20, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Horseshoe Bend, Ida. | Date of Burial: June 21 1929
20. Undertaker: C D Buckmun | Address: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66453

PLACE OF DEATH
County of Bonner
City of clarksfork
Registration District No. 88
Primary Registration District No. 3457
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ellen M Tarbox

(a) Residence. No. Clarks fork St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 3 1855

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Johnathan Easterly
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa
12. MAIDEN NAME OF MOTHER Sarah J Mc Conkie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Bess L Teague
(Address) Clarksfork Idaho

15. Filed 6-20 1929 John Larson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1928, to Feb 12, 1929
that I last saw h[illegible] alive on July, 1929
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:
Chr. Myocarditis
Contributory Cholecystitis
(duration) 3 yrs. — mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? Clinical
(Signed) R S Moss, M. D.
Feb 13, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clarksfork Idaho — Date of Burial: 2/14 1929
20. Undertaker: Turnbull Co — Address: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66454

PLACE OF DEATH

County of Bonner
City of Hope

Registration District No. 80
Primary Registration District No. 2157
(No. Hope Ida)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

49

2. FULL NAME Mrs Helen Williams
(a) Residence. No. Hope Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of W. E. Williams

6. DATE OF BIRTH (month, day and year) Feb 22 1859

7. AGE: Years 70 | Months | Days | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) William Stark
12. MAIDEN NAME OF MOTHER Minn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn

14. Informant Walter E Williams
(Address) Hope Idaho

15. Filed 6-20, 1929 John Larson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1928, to Feb-15, 1929
that I last saw h___ alive on ___, 19___
and that death occurred, on the date stated above, at 9:15 P.m.
The CAUSE OF DEATH* was as follows: Uterine Carcinoma
(duration) 2 yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)
(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Floyd G Weagle M.D.
2-18, 1929 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hope Idaho | Date of Burial: Feb 19 1929

20. Undertaker: Turnbull Co | Address: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66455

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bonner

City of Clarkafork

Registration District No. 86

Primary Registration District No. 2137

Local Registrar's No. 11

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

147

2. FULL NAME Jefferson F. Teague

(a) Residence. No. Clarkafork Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie L. Teague

6. DATE OF BIRTH (month, day and year) Feb 24 1867

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	4	75	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS

10. NAME OF FATHER Logan Teague

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. C.

12. MAIDEN NAME OF MOTHER Mary Ann Reid

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Mrs. J. F. Teague

(Address) Clarkafork Ida.

15. Filed 6-20, 1929 John Larson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probable Heart Disease

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. L. Moon Coroner.

June 17, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clarkafork Idaho	6/18 1929
20. Undertaker Tunnell Co	Address Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66456

PLACE OF DEATH

County of Bonner
City of Blanchard
Registration District No. 85
Primary Registration District No. 2185
(No.)
Local Registrar's No. 21

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Clarence Hamburg

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Flora Wald

6 DATE OF BIRTH (month, day and year) April 25, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mill Worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Marinette
(State or country) Wis.

PARENTS

10 NAME OF FATHER Earnest Hamburg
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Elizabeth Lamere
13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant J. W. Hamburg
(Address) Newport, Wash.

15 Filed June 26, 1929 R. E. Wessa
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH about June (Month) 25th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Suicide by Firearms.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) L. A. Moon, M. D.
June 26, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Newport, Wash.	
20. Undertaker	Address
Booth & Sherman	Newport, Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66458

PLACE OF DEATH
County of Bonner
City of Priest River

Registration District No. 83
Primary Registration District No. 2185
(No.)

Local Registrar's No. 19

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Thomas H. Fisher

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Cora E. Phelps

6 DATE OF BIRTH (month, day and year) March 9th. 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	2	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maiden Rock Wisconsin

PARENTS
10 NAME OF FATHER Henry Fisher
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Susana Obrien
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Cora Fisher
(Address) Newport, Washington.

15 Filed June 7, 1929 D. E. Messer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 6th. (Day) 1929. (Year) 19

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1929, to June 6, 1929, that I last saw h.was alive on June 6, 1929, and that death occurred, on the date stated above, at 12:40 P.m.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) Years. yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) A. D. Scholbe M. D.
June 6, 1929 (Address) Newport, Wash.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Newport, Washington	
20. Undertaker	Address
Booth & Sherman	Newport

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 5 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66459

County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
Local Registrar's No. 18

(No. Priest River Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Joan Beverly

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 27, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Priest River,
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Edgar D. Beverly

11. BIRTHPLACE OF FATHER (city or town) Louisville,
(State or Country) Ky.

12. MAIDEN NAME OF MOTHER Nellie Regen

13. BIRTHPLACE OF MOTHER (city or town) Grinell,
(State or Country) Iowa.

14. Informant E. D. Beverly
(Address) Priest River, Ida.

15. Filed June 3, 1929 R. E. Wessa
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to June 1, 1929
that I last saw her alive on June 1, 1929
and that death occurred, on the date stated above, at 8:15 P m.
The CAUSE OF DEATH* was as follows:
Pre Maturity

(duration) yrs. mos. 6 ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clynical Signs
(Signed) R. R. Lowes, M. D.
June 3, 1929 (Address) Priest River Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Woodmen Cemetery	June 3, 1929

20. Undertaker — Address
Moon Mortuary Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66460

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No. 534 Erie Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minnie Buck
(a) Residence. No. Sandpoint, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 8th. 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	8	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Atchison, Kansas.

PARENTS

10. NAME OF FATHER James Harvey Buck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Berkeley Springs West Virginia
12. MAIDEN NAME OF MOTHER Sarah B. Frost
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Johnson County Missouri.

14. Informant Mrs. Wolf
(Address) 534 Erie Street

15. Filed July 1, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1927, 19..., to June 29, 1929
that I last saw her alive on June - 29, 1929
and that death occurred, on the date stated above, at 3:55 P. M.
The CAUSE OF DEATH* was ~~as follows~~:
Cerebral Tumor
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X-Ray, Clinical
(Signed) Floyd B. Wendle M. D.
July 1, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Atchison, Kansas	19

20. Undertaker	Address
Moon Mortuary by O.A.T.	Sandpoint Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66461

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No. 212 Main Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Earnest H. Cooper

(a) Residence. No. 212 Main Street St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Un

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 14, 1852

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	8	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant J.A.Adams
(Address) 212 Main Street.

15. Filed June 29, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1929, to June 27, 1929
that I last saw him alive on June 26, 1929
and that death occurred, on the date stated above, at 10:00P m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) Wm F. Tyler, M. D.
June 29, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Portland, Oregon	June 29 1929

20. Undertaker	Address
Moon Mortuary	Sandpoint, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66462

PLACE OF DEATH

County of Bonner
City of Colburn,
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Wheeler Myers

(a) Residence. No. Colburn, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 7, 1909

7. AGE	Years	Months	Days	If LESS than 1 day,
20	Years	6	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer) Brown Timber Co.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cle Ellam, Wash.

PARENTS

10. NAME OF FATHER Fred Myers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wyoming.
12. MAIDEN NAME OF MOTHER Edith Hubble
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Junction City Kansas

14. Informant Fred Myers
(Address) Colburn, Idaho

15. Filed June 24, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 22nd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Accidental Traumatism;
hit by a falling snag.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L.G. Moon. Coroner.
June 22, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	June 25, 1929

20. Undertaker	Address
L.G. Moon	Sandpoint, Idaho

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66463

PLACE OF DEATH

County of Bonner
City of Granite
Registration District No. 78
Primary Registration District No. 2155
(No. Granite, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME James Larson

(a) Residence. No. Granite, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Emma Larson

6. DATE OF BIRTH (month, day and year): March 12, 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	3	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sewden
12. MAIDEN NAME OF MOTHER: -----Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Walter Larson
(Address): Kootenai, Idaho

15. Filed June 19, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to June 18, 1929
that I last saw him alive on June 16, 1929
and that death occurred, on the date stated above, at 12:45 P.M.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease
(duration) 7 yrs. mos. ds.
CONTRIBUTORY (Secondary) Bedfast for 6 Years
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) V. B. Grant M. D.
June 19, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	June 20, 1929
20. Undertaker	**Address**
Moon's Mortuary,	Sandpoint, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66464

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leon G Skavland

(a) Residence. No. St. Selle Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 19 1907

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	21	11	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10. NAME OF FATHER: Nicoli Skavland
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Sigrid Holdoss
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Mrs S. Skavland
(Address) Selle Ida

15. Filed June 22, 1929 Viola Adler Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13, 1929, to June 17, 1929, that I last saw him alive on June 17, 1929, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage & shock from injury right arm-head (duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) Wm F. Fuller, M. D.
June 19, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
West Mond Ida	June 22 1929
20. Undertaker: Turnbull Co	Address: sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66466

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No. 56 Milltown, Sandpoint, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dorothy Tabea Christianson

(a) Residence. No. Sandpoint, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of George C. Christianson

6. DATE OF BIRTH (month, day and year) Sept. 2, 1893

7. AGE Years	Months	Days	If LESS than 1 day,
36	9	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Morgan, Minn.

PARENTS

10. NAME OF FATHER
Anton Ecker

11. BIRTHPLACE OF FATHER (city or town) (State or Country)
Germany

12. MAIDEN NAME OF MOTHER Wilhemia Prahl

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)
Germany

14. Informant Geo. C. Christianson
(Address) 56 Milltown, Sandpoint, Idaho

15. Filed June 14, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Apr 15, 1929, to June 12, 1929
that I last saw her alive on June 11, 1929
and that death occurred, on the date stated above, at 12:30 A.m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical & chemical
(Signed) Wm F. Tyler, M. D.
June 14, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	June 16, 1929
20. Undertaker	Address
L.G. Moon Mortuary	Sandpoint, Idaho.

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66467

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No. 619 N. Sixth Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

47

2. FULL NAME Josephine H. Chubb

(a) Residence. No. Sandpoint, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Arthur J. Chubb

6. DATE OF BIRTH (month, day and year) Jan 6, 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	5	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hudson Wis.

PARENTS

10. NAME OF FATHER W.B. Hollister

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Christiana Gelmore

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Gertrude J. Chubb
(Address) Sandpoint, Idaho R4. B.E

15. Filed June 10 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December, 1928, to June 9th, 1929
that I last saw her alive on June 6th, 1929
and that death occurred, on the date stated above, at 11:15A m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of Jan 15-1929
Was there an autopsy?
What test confirmed diagnosis? Microscopic

(Signed) H. B. Evans M. D.
6-9-29 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	6/10 1929

20. Undertaker	Address
Moon Mortuary, Sandpoint,	Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66468

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No. Page Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1880

2. FULL NAME Tranquilino Gubatan

(a) Residence. No. Heron Mont St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Yellow

5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 20 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work R R Section work

(b) General nature of industry, business, or establishment in which employed (or employer) NPRR

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Philipine Islands

PARENTS

10. NAME OF FATHER Francisco Gubatan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) P.I

12. MAIDEN NAME OF MOTHER Eugenio

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) P I

14. Informant Page Hospital
(Address) Sandpoint Idaho

15. Filed June 10, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7, 1929 to June 7, 1929 that I last saw him alive on June 7 1929 and that death occurred, on the date stated above, at 11 45 a m.

The CAUSE OF DEATH* was as follows:
Accidental traumatism by railway.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Cedar Spur Montana

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Legs crushed below hips

(Signed) O F Page, M. D.

June 9, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lakeview Cemetery — Date of Burial 6/10 1929

20. Undertaker Turnbull Co — Address Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66469

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

29

2. FULL NAME Melvin Peter Christianson

(a) Residence. No. Sandpoint, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 8 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 1, 1921.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
8	4	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sandpoint, Idaho

PARENTS

10. NAME OF FATHER Charles Gust Christianson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norvik Norway

12. MAIDEN NAME OF MOTHER Nellie Loraine Turnbull

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Evergreen Minnisota.

14. Informant Chas. G. Christianson

(Address) Sandpoint, Idaho

15. Filed June 6, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1929, to June 4, 1929

that I last saw him alive on June 4, 1929

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Chemical

(Signed) Wm F. Tyler, M. D.

June 5, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	June 7th. 1929

20. Undertaker	Address
Moon Mortuary,	Sandpoint, Idaho

RECEIVED MAY 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66470

PLACE OF DEATH
County of Bonneville
City of Popular

Registration District No. 13
Primary Registration District No. 21 1-0
Local Registrar's No. 9

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Taylor Nield

(a) Residence. No. Popular Idaho St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Eleanore C. Nield

6. DATE OF BIRTH (month, day and year) Aug. 28, 1865

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	8	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) San Pete Utah

PARENTS
10. NAME OF FATHER John Nield
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Emily Broadbent
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant P. L. Nield
(Address) Riggins Idaho

15. Filed May 13, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1929 to May 11, 1929
that I last saw h[illegible] alive on May 9, 1929
and that death occurred, on the date stated above, at 11:45 P m.
The CAUSE OF DEATH* was as follows:

Pneumonia Lobular
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Dan A Price, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Swan Idaho	May 14 1929
20. Undertaker	Address
Jack T. Wood	Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66471

PLACE OF DEATH

County of Bonneville. Registration District No. 73

City of Idaho Falls. Primary Registration District No. 2 1 V - D Local Registrar's No. 21

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Belle. Mc Nair.

(a) Residence. No. 255 - 4 St. St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white.	married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mr E. McNair. Vet.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	6	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bedford Iowa.

PARENTS

10. NAME OF FATHER John Burks.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky.

12. MAIDEN NAME OF MOTHER Margaka Proto.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) West Virginia

14. Informant Mr E. McNair (Vet.) (Address) Idaho Falls. Ida.

15. Filed May 2, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1 (Day) 1929. (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw her alive on 19

and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis — Arterio-Sclerosis

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure Symptoms

(Signed) H D Swaffin, M. D.

May 2, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida.	May 4 1929.
20. Undertaker	Address
V. F. McHaro	Idaho Falls.

RECEIVED JUN 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66472

PLACE OF DEATH
County of Bonneville
City of Iona

Registration District No. 73
Primary Registration District No. 2 1 4 0
Local Registrar's No. 9

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary A. Owens

(a) Residence. No. Iona, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of C. J. Owens

6. DATE OF BIRTH (month, day and year) February 8, 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	2	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Isaac Stevens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Frances Gene
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant C. S. Owens
(Address) Idaho Falls Route #7

15. Filed May 6, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb, 1926, to May 5, 1929
that I last saw her alive on May 4, 1929
and that death occurred, on the date stated above, at 4-15 a m.
The CAUSE OF DEATH* was as follows:

Ch. Myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination

(Signed) [illegible] M. D.
5/6 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Iona, Idaho	May 8 1929
20. Undertaker	Address
J. A. Wood	Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66473

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 13
Primary Registration District No. 1210
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 93

7108 V

2. FULL NAME Ray Heyrum Holland

(a) Residence. No. [illegible] Rigby Route #1 St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 9, 1917

7. AGE	Years	Months	Days	If LESS than 1 day,
	11	10	27	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rigby Route #1 Idaho

PARENTS

10. NAME OF FATHER J. H. Holland
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden Utah
12. MAIDEN NAME OF MOTHER Bradlea Westergard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wyoming

14. Informant J. H. Holland
(Address) Rigby Route #1 Idaho

15. Filed May 9, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to May 6, 1929
that I last saw him alive on May 6, 1929
and that death occurred, on the date stated above, at 5-30 P.M.
The CAUSE OF DEATH* was as follows:
Epidemic Cerebro Spinal Meningitis
(duration) yrs. mos. ✓ ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Rigby, Idaho RFD
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) W. Ray Hatch, M. D.
May 8, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grant Idaho	May 9 1929
20. Undertaker Jack A. Woods	Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66474

PLACE OF DEATH

County of Bonneville. Registration District No. 23

City of Idaho Falls. Primary Registration District No. 2150 Local Registrar's No. 94

(No. L.D.S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wendel Everett Hahn.

(a) Residence. No. 285 - 13 St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 28 1923

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	8	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls. Ida.

PARENTS

10. NAME OF FATHER Wendel Hahn.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Carroll. Iowa.
12. MAIDEN NAME OF MOTHER Bess Everett.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho Falls Ida

14. Informant Wendel Hahn.
(Address) Idaho Falls Ida.

15. Filed May 11, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8, 1929 to May 9, 1929
that I last saw him alive on , 19
and that death occurred, on the date stated above, at 4:25 P.M.
The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Laboratory

(Signed) [signature], M. D.
, 19 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	May 10 1929

20. Undertaker W. F. McHan. Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 19 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66475

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. L. C. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 95

2. FULL NAME Garth Lee Killian
(a) Residence. No. Shelley, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced, (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 19 1913

7. AGE Years 15 Months 7 Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Goshen, Idaho

PARENTS
10. NAME OF FATHER Celos Killian
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Thorne
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant M. Celos Killian
(Address) Shelley, Idaho

15. Filed May 10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to May 8, 1929
that I last saw h alive on May 8, 1929
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows: Gunshot wound abdomen Perforation liver - stomach jejunum
(duration) yrs. mos. 1/2 ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. 1/2 ds.

18. Where was disease contracted if not at place of death? Shelley, Idaho
Did an operation precede death? Yes Date of May 7-29
Was there an autopsy? No
What test confirmed diagnosis? Surgery
(Signed) [signature], M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley, Idaho — Date of Burial May 10 1929

20. Undertaker Jack A. Wood — Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66476

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 214-0

(No. L. D. S. Hospital)

Local Registrar's No. 96

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Clarke Ward

(a) Residence. No. Ashton, Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 19, 1925

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	6	22	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Evarts, Kentucky

PARENTS

10. NAME OF FATHER Guy Paul Ward

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Anna Van Deusen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mitchell, New Mexico

14. Informant Mrs. Guy P. Ward

(Address) Ashton Idaho

15. Filed May 10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to May 8, 1929

that I last saw him alive on May 8, 1929

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Spinal Meningitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ashton Idaho

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) [signature], M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ashton Idaho	May 10, 1929
20. Undertaker	Address
Funk & Dunn	

RECEIVED JUN 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66477

PLACE OF DEATH
County of Bonneville. Registration District No. 73
City of Idaho Falls. Primary Registration District No. 21 N-D
Local Registrar's No. 97

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jay Mansfield.

(a) Residence. No. 8 miles in Country St.
(Usual place of abode)
Length of residence in city or town where death occurred. 2 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 13 1926.

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	9	27	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Roberts Idaho.

PARENTS

10. NAME OF FATHER John Mansfield
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Charlotte Berry.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Murour Utah.

14. Informant John Mansfield.
(Address) Idaho Falls Ida.

15. Filed May 17, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May. 11 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h[illegible]live on , 19
and that death occurred, on the date stated above, at 6.17 m.
The CAUSE OF DEATH* was as follows:
Meningetis.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J Poulton M. D.
5/13/, 1929 (Address) Ida Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Iona Idaho.	May 12 1929

20. Undertaker W. F. McHan. Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FORM V. S. No. RECEIVED JUN 19 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2150

(No. ..... St.)

State File No. 66478

Local Registrar's No. 9 f

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Murphy

143a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: — (Write the word)

6. DATE OF BIRTH: May 20 1929 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 20 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF Father: Thos Hugh Murphy

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Iona Williams

13. BIRTHPLACE OF MOTHER (State or Country): Emery Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Alma Williams

(Address) Idaho Falls R1 #7

15. Filed May 21 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 20 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1929, to 5/20 1929, that I last saw him alive on May 20 1929, and that death occurred on the date stated above, at 10 50 P.M.

The CAUSE OF DEATH* was as follows:

Therapeutic Abortion at 4 1/2 mo

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Placenta Praeva & hemorrhage

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) [signature] M. D.

5/21 1929 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? Montana

Former or usual residence Montana

19. PLACE OF BURIAL OR REMOVAL: Cremation

DATE OF BURIAL 19

20. UNDERTAKER: Crane

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66479

Registration District No. 73
Primary Registration District No. 21 V-0
Local Registrar's No. 99

PLACE OF DEATH

County of Bonneville
City of Garfield
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James William Bone.

(a) Residence. No. .... St. ....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of [redacted] Pearl (Davis) Bone.

6. DATE OF BIRTH (month, day and year) Jan. 4, 1863

7. AGE	Years	Months	Days	If LESS than 1 day,
	66	4	7	.... hrs. or .... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): ....
(c) Name of employer: Self.

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: John Bone.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Hanna Slater.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant Pearl Davis Bone
(Address) Lehi Utah.

15. Filed May 13, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ...., 19.... to ...., 19....
that I last saw h.... alive on ...., 19....
and that death occurred, on the date stated above, at .... m.
The CAUSE OF DEATH* was as follows: Carcinoma of neck with metastasis.

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ....
(duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of ....
Was there an autopsy? no
What test confirmed diagnosis? ....
(Signed) W. A. West, M. D.
...., 19.... (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lehi, Utah	5/19/29 19

20. Undertaker [signature] Address Rigby Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66480

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 13
Primary Registration District No. 210-0
(No. L. G. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 100

117

2. FULL NAME Dean Nelson Oler
(a) Residence. No. Shelley, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 10, 1914

7. AGE Years 10 Months 8 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley, Idaho

PARENTS
10. NAME OF FATHER James Oler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) American Fork, Utah
12. MAIDEN NAME OF MOTHER Annie C. Nelson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mr James Oler
(Address) Shelley, Idaho

15. Filed May 18, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to May 16, 1929
that I last saw him alive on May 16, 1929
and that death occurred, on the date stated above, at 4:30 a.m.
The CAUSE OF DEATH* was as follows:
Acute perforative appendicitis with diffuse peritonitis
(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) —
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Shelley Idaho
Did an operation precede death? yes Date of May 14, 1929
Was there an autopsy? no
What test confirmed diagnosis? Operation
(Signed) H Ray Hatch M. D.
May 18, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley Idaho
Date of Burial May 19 1929

20. Undertaker Jack T. Wood
Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 19 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66481

Registration District No. 73

Primary Registration District No. 2150

Local Registrar's No. 101

(No. L. O. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clinton Crooks

(a) Residence. No. Shelley, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred, yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

167 ✓

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 18, 1924

7. AGE Years Months Days 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley, Idaho

PARENTS

10. NAME OF FATHER Don J. Crooks

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Edith Oler

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mr. O. J. Crooks

(Address) Shelley, Idaho

15. Filed May 23, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 22 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-18-, 1924, to 5-22-, 1924

that I last saw him alive on 5-22-24, 1924

and that death occurred, on the date stated above, at 8-15 P m.

The CAUSE OF DEATH* was as follows:

Jaundice Neonatorum

(duration) yrs. mos. X ds.

CONTRIBUTORY (Secondary) Atresia of hepatic ducts.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Oettler, M. D.

5/23, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley, Idaho

Date of Burial May 23 1929

20. Undertaker Jack A. Wood

Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66482

Registration District No. 73
Primary Registration District No. 2170
Local Registrar's No. 02

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Blake

(a) Residence. No. Idaho Falls, Idaho St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 25, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER Burton Blake
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Benton, Utah
12. MAIDEN NAME OF MOTHER Ethel Armstrong
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Colorado

14. Informant Burton Blake
(Address) Idaho Falls, Idaho

15. Filed May 27, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from May 26, 1929, to May 26, 1929
that I last saw h[illegible] alive on May 26, 1929
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows:

Premature, poorly nourished Infant.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical.
(Signed) Harry P. Wilson, M. D.
May 27, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Idaho	May 29 1929
20. Undertaker Jack A. Wood	Address Idaho Falls

RECEIVED JUN 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66483

PLACE OF DEATH

County of Bonneville.
City of Idaho Falls.
Registration District No. 73
Primary Registration District No. 21 J-0
Local Registrar's No. 103
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Blanche H. Delin.
(a) Residence. No. 366. Walnut. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J W Delin.

6. DATE OF BIRTH (month, day and year) Nov 18 - 1871

7. AGE: Years 57 | Months 6 | Days 13. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake City Utah.

PARENTS

10. NAME OF FATHER Stanley Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Hannah Howard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant J. W. Delin
(Address) Idaho Falls Ida.

15. Filed 6/1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 15, 1929, to May 31, 1929
that I last saw her alive on ....., 19..
and that death occurred, on the date stated above, at 5 30 P.m.
The CAUSE OF DEATH* was as follows: Carcinoma uterus with metastasis to lungs and neck.
(duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Same
(duration) one yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? yes Date of Mar. 15-29.
Was there an autopsy? No
What test confirmed diagnosis? Biopsy
(Signed) H. D. [signature], M. D.
June 1, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida | Date of Burial: June 2 1929

20. Undertaker: V. F. McHan | Address: Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66484

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2190
Local Registrar's No. 104

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chris P. Poulsen

(a) Residence. No. Idaho Falls, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

88 B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. C. P. Poulsen

6. DATE OF BIRTH (month, day and year) Feb 14 1870

7. AGE: Years 59 | Months 3 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retire Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS
10. NAME OF FATHER Peter Poulsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Laura Roller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant M. Guy A. Poulsen
(Address) Idaho Falls, Idaho

15. Filed May 24, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18, 1929, to May 22, 1929
that I last saw him alive on May 22, 1929
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:
Acute Myocarditis
..... (duration) ..... yrs. ..... mos. 6 wks ds.
CONTRIBUTORY (Secondary) Cirrhosis of Liver
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical Only
(Signed) [signature] M.D.
May 24, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho | Date of Burial: May 26 1929

20. Undertaker: Jack A. Wood | Address: Idaho Falls

RECEIVED JUN 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66485

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 21 N-0
Local Registrar's No. 104
(No. 170 ✓)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Benjamin Ritchie
(a) Residence. No. Iona, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Benjamin Ritchie
6. DATE OF BIRTH (month, day and year): July 29, 1864
7. AGE: Years 64 | Months 8 | Days 240 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer & Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Ogden, Utah

PARENTS
10. NAME OF FATHER: James Ritchie
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Hannah Bright
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Benj. Ritchie Jr.
(Address) Salt Lake City Utah
15. Filed May 27, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 23 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr. 29, 1929 to May 23, 1929
that I last saw h[illegible] alive on May 21, 1929
and that death occurred, on the date stated above, at 2-30 P. m.
The CAUSE OF DEATH was as follows:
Gun-shot wound chest (suicidal)
Had suffered from cardiac and renal disease for years previously
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of —
Was there an autopsy? No —
What test confirmed diagnosis?
(Signed) John O. Mellas, M. D.
May 24, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Iona, Idaho — Date of Burial: May 26 1929
20. Undertaker: Jack A. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 19 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66486

Registration District No. 13

Primary Registration District No. 2140

Local Registrar's No. 106

(No. L. O. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lydia Elizabeth Lark

(a) Residence. No. Ucon, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) November 11, 1912

7. AGE: Years 16 Months 6 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ucon, Idaho

PARENTS

10. NAME OF FATHER Frank Lark

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Luella Peterson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mr. Frank Lark

(Address) Ucon, Idaho

15. Filed May 25, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 23 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 23, 1929

that I last saw her alive on May 23, 1929

and that death occurred, on the date stated above, at 12-10 P m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ucon, Idaho

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Coll Clew, M. D.

May 25, 1929 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ucon, Idaho — Date of Burial: May 25 1929

20. Undertaker: Jack A. Wood — Address: Idaho Falls

RECEIVED JUN 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66487

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 13
Primary Registration District No. 2150
(No. Water Ave)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 107

2. FULL NAME Infant. Roberts

(a) Residence. No. Water Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 24-29

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work No.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls

PARENTS

10. NAME OF FATHER Carl Roberts
11. BIRTHPLACE OF FATHER (city or town) (State or Country) No.
12. MAIDEN NAME OF MOTHER Mary E Sledd
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Carl Roberts
(Address) Idaho Falls Ida

15. Filed May 27, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to May 26, 1929
that I last saw him alive on May 26, 1929
and that death occurred, on the date stated above, at 2 p. m.
The CAUSE OF DEATH* was as follows:
Spasmodic Colic

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G.O. Thupperle M.D.
, 19 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	May 29 1929

20. Undertaker	Address
Cliff Hayes	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66488

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 214-0

Local Registrar's No. 101

(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Fern Elizabeth Clark.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 24-1915

7. AGE

Years	Months	Days	If LESS than 1 day,
13	6	6	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Ida.

PARENTS

10. NAME OF FATHER Homer Clark.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Davenport Iowa.

12. MAIDEN NAME OF MOTHER Elizabeth Emery.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canton Ill.

14. Informant Homer Clark.
(Address) Idaho Falls. Ida

15. Filed 6/1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to May 31, 1929 that I last saw her alive on May 30, 1929 and that death occurred, on the date stated above, at 7 30 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. D. Jenkins M. D.

May 31, 1929 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: June 2, 1929

20. Undertaker: V. F. McHan. Address: Idaho Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66489

Registration District No. 13

Primary Registration District No. 21-0

Local Registrar's No. 109

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

199

2. FULL NAME Marjorie Linden McDonald Daley

(a) Residence. No. 462 - H Street St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of R. O. Daley

6. DATE OF BIRTH (month, day and year) June 30, 1902

7. AGE Years 26 Months 11 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Registered nurse

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dean, Montana

PARENTS

10. NAME OF FATHER Richard McDonald

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Evelyn Huskin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Dorothy D. McDonald

(Address) Dean, Montana

15. Filed June 3, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at about 10 A. m.

The CAUSE OF DEATH* was as follows: That from the evidence, death from cyanide poison, by ~~[illegible]~~ hands unknown to their jury.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. [illegible], Allen, Coroner

June 3, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Absarokee, Montana

Date of Burial June 5 1929

20. Undertaker Jack A. Wood

Address Idaho Falls

RECEIVED JUL 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66490

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 1V-0
Local Registrar's No. 11
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marguarette Cutler

(a) Residence. No. (Usual place of abode) St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white.	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Josiah Cutler.

6. DATE OF BIRTH (month, day and year) March 17-1840

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	2	16.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Maine.

PARENTS

10. NAME OF FATHER Michael Cutter.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Eliza. —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland.

14. Informant Mrs Sadie Hecker.
(Address) Idaho Falls Ida

15. Filed 6/4, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 3 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to June 3, 1929
that I last saw her alive on June 2, 1929
and that death occurred, on the date stated above, at 7 A. m.
The CAUSE OF DEATH* was as follows: Fracture L&R Femur at Surgical neck

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Hypostatic Pneumonia
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X Ray
(Signed) [illegible], M. D.
June 3, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida.	June 5 1929

20. Undertaker V. F. M Han Address Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66491

PLACE OF DEATH
County of Bonneville. Registration District No. 73
City of Idaho Falls. Primary Registration District No. 2154-0
Local Registrar's No. 111
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marie Clay

(a) Residence. No. Cliff St. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 23-1913.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
15	10	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Havre Mont.

PARENTS
10. NAME OF FATHER Wm John Clay.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Shreveport. La.
12. MAIDEN NAME OF MOTHER May Connell.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ft Stafford. N.D.

14. Informant Mary Connell.
(Address) Idaho Falls Ida.

15. Filed 6/7, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1929, to June 4, 1929,
that I last saw h[illegible] alive on May 4, 1929,
and that death occurred, on the date stated above, at 2 [illegible] m.
The CAUSE OF DEATH* was as follows:
Tube Culosis Lungs
1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No Laboratory
What test confirmed diagnosis?
(Signed) [illegible], M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	June 6 1929.

20. Undertaker V. F. McHan Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 1-25 M. 1-19

RECEIVED JUL 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66492

Local Registrar's No. 12

1. PLACE OF DEATH

County of Bonneville Registration District No. 73

City of Idaho Falls Primary Registration District No. 21 V-D

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jane Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: 5 (Month) 28 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 14 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Babe

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): L D S Hospital Idaho Falls

10. NAME OF Father: Lorenzo L. Hansen

11. BIRTHPLACE OF FATHER (State or Country): Shelley Ida.

12. MAIDEN NAME OF MOTHER: Mary Hortense Allred

13. BIRTHPLACE OF MOTHER (State or Country): Afton Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lorenzo Hansen

(Address) Shelley Ida.

15. Filed 6/6 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-27-1929 to 5-27-1929 that I last saw her alive on 5-27-1929 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature Birth

17 months' gestation

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin Cutler M. D.

5/29/1929 (Address) Shelley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ½ ds.

Where was disease contracted if not at place of death? at home

Former or usual residence Shelley Ida.

19. PLACE OF BURIAL OR REMOVAL: Shelley Cemetery — DATE OF BURIAL: 5-28-1929

20. UNDERTAKER: none — ADDRESS: .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Salesman,** (b) **Grocery;** (a) **Foreman,** (b) **Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of .....(name origin; "Cancer' is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66493

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2140

Local Registrar's No. 113

(No. Water and)

(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Mrs Estelle Gesas

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Barney Gesas

6. DATE OF BIRTH (month, day and year) Jan 23-1873

7. AGE: 56. Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ?

PARENTS

10. NAME OF FATHER Raphael Raphael

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Anna Raphael

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Joseph Gesas
(Address) Idaho Falls Ida.

15. Filed 6/6, 1929 [signature] Registrar
Dr Wilson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June [illegible] 5th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1928, to June 5, 1929
that I last saw her alive on June 5, 1929
and that death occurred, on the date stated above, at 6 45 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Right)

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation, Myocarditis (duration) 1 yrs. 3 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry L. Willson, M. D.

June 6th, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Brooklyn NY. Date of Burial: June 1929

20. Undertaker: Cliff Hayes Address: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66494

RECEIVED JUL 9, 1929

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 21V-0
Local Registrar's No. 114

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Effie Jane Whitmill

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 5-1890

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	1	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Liberty Bear Lake Co Idaho

PARENTS

10. NAME OF FATHER Wm A. Hymas

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Saloma Hammon

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Geo Lew Whitmill
(Address)

15. Filed June 11, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to June 10, 1929
that I last saw h alive on June 10, 1929
and that death occurred, on the date stated above, at 9:00 p.m.
The CAUSE OF DEATH* was as follows: 9 hours.
Followed severe attack of Rt Cholecystitis for Pyelitis.
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Rt Pyelitis and cystitis (duration) yrs. mos. 30 ds.

18. Where was disease contracted if not at place of death? Blackfoot, Ida
Did an operation precede death? Yes Date of Exploratory
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Lab
(Signed) J. A. Ray M. D.
June 11, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Blackfoot Idaho	June 1929

20. Undertaker E J Peck Address Blackfoot Idaho

RECEIVED JUL 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66495

Local Registrar's No. 11 V

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2 1 V-0
(No. L. D. S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME Fred H Fornetin.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male.	white.	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Fred Fornetin.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	1	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Council Bluffs Iowa.

PARENTS

10. NAME OF FATHER Henry Fornetin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Louise Steineke
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs Fred Fornetin
(Address) Idaho Falls Ida.

15. Filed June 12, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7, 1929 to June 10, 1929
that I last saw h[illegible] alive on June 10, 1929
and that death occurred, on the date stated above, at 6.45 P m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
Embolus left femoral artery
(duration) 5 yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Acute Appendicitis
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? V
Did an operation precede death? Yes Date of June 7-29
Was there an autopsy? no
What test confirmed diagnosis? Op. Symptoms.
(Signed) H D Hunkin, M. D.
June 7, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	June 13 1929

20. Undertaker W. F. McHan Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66496

Local Registrar's No. 116

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 21V-0
(No. 640 S. [illegible])
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Euphema Nelson

(a) Residence. No. [illegible] Capital Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Nelson

6. DATE OF BIRTH (month, day and year) 1891

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colorado.

PARENTS

10. NAME OF FATHER Same
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colorado.
12. MAIDEN NAME OF MOTHER Don't Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant John Nelson
(Address) Idaho Falls Ida

15. Filed June 12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to June 9, 1929
that I last saw h[illegible] alive on June 9, 1929
and that death occurred, on the date stated above, at 1137 p. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
probably tubercular in origin
(duration) yrs. mos. 4 hrs. dys.
CONTRIBUTORY (Secondary) Tuberculosis ?
unknown (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Clinical data

(Signed) Harry L. Nelson, M. D.
June 12, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls Ida — Date of Burial June 13 1929

20. Undertaker Cliff Hagen — Address Idaho Falls

RECEIVED JUL 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66497

PLACE OF DEATH
County of Bonneville
City of Idaho Falls.

Registration District No. 13
Primary Registration District No. 2170
(No. L. D. S. Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 117

2. FULL NAME Meshach Lewis Williams

(a) Residence. No. ..... St. Ririe, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of [redacted] Rebecca J Williams Williams.

6. DATE OF BIRTH (month, day and year) June 3 1858

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	0	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9. BIRTHPLACE (city or town) (State or country) Salt Lake City, Utah.

PARENTS

10. NAME OF FATHER Meshach S. Williams.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales.
12. MAIDEN NAME OF MOTHER Elizabeth Lewis.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales.

14. Informant Thos E Williams
(Address) Rigby, Idaho R. #2

15. Filed 6/17, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28, 1929 to June 9, 1929
that I last saw h alive on June 9, 1929
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza - Obstruction
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? Rigby Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
June 12, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shelton, Idaho.	6/13/29

20. Undertaker [signature] Address Rigby

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1929

PLACE OF DEATH

County of Bonnyville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66498

Registration District No. 73

Primary Registration District No. 214-0

Local Registrar's No. 118

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1830

2. FULL NAME Jesse ~~Francis~~ ~~Frank~~ Barker

(a) Residence. No. Salt Lake City - Utah St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Dec 23 1913 ~~July 7, 1914~~

7. AGE: Years 15 Months 5 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Blackfoot, Ida

PARENTS

10. NAME OF FATHER: Harold Barker

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Parkers Prairie Minn.

12. MAIDEN NAME OF MOTHER: Ada Blair

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: H J Barker

(Address): 111 S 4th Ave

15. Filed June 17, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1929, to June 16, 1929 that I last saw him alive on June 16, 1929 and that death occurred, on the date stated above, at 11:10 P m.

The CAUSE OF DEATH* was as follows:

Gunshot wound of abdomen

(duration) ..... yrs. ..... mos. 8 hrs.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Blackfoot, Ida

Did an operation precede death? Yes Date of June 16, 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W W Beck, M. D.

June 17, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salt Lake City

Date of Burial: 19

20. Undertaker: E J Peck

Address: Blackfoot Idaho

RECEIVED JUL 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66499

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 214-0

Local Registrar's No. 119

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alfred Foster

(a) Residence. No. Bingham & Shelly St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 19 1866

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	3	26.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Franklin Ida

PARENTS

10. NAME OF FATHER Abe Foster.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Chicago Ill.

14. Informant Clifford Foster

(Address) Idaho Falls Ida.

15. Filed 6/18, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw him alive on ....., 19.....

and that death occurred, on the date stated above, at 3 - P. m.

The CAUSE OF DEATH* was as follows:

chronic myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? History

(Signed) [signature] M.D.

June 17, 1929 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida

Date of Burial: June 18 1929.

20. Undertaker: V. F. McHan

Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66500

PLACE OF DEATH
County of Bonneville.
City of Idaho Falls.

Registration District No. 73
Primary Registration District No. 2150
(No. E. D. S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 120

101a

2. FULL NAME Ross Tullis.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 3 - 1925

7. AGE: Years 4 Months 5 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Leamington Utah.

PARENTS
10. NAME OF FATHER C. W. Tullis.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tinto Co. Utah.
12. MAIDEN NAME OF MOTHER Ethel Leavitt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Gunlock. Utah.

14. Informant C. W. Tullis.
(Address) Shelly Idaho

15. Filed 6/21, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 20 (Day) 1929. (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-19-29, 19..., to 6-20-, 1929
that I last saw him alive on 6-19, 1929
and that death occurred, on the date stated above, at 12 20 A.m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Edwin Custer, M. D.
6-21-, 1929 (Address) Shelly,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shelly Idaho. Date of Burial: June 21 1929.
20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66501

PLACE OF DEATH

County of Bonneville. Registration District No. 23

City of Idaho Falls. Primary Registration District No. 21-D

Local Registrar's No. 121

(No. L. D. S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Colene. Birge.

(a) Residence. No. Blackfoot, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred: yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 6-1929

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot. Idaho.

PARENTS

10. NAME OF FATHER Thos. Birge.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Nida Hamblin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Victor Ida.

14. Informant Thos. Birge.
(Address) Blackfoot. Ida.

15. Filed 6/21, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 17 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1929, to June 17, 1929
that I last saw h[illegible] alive on June 16, 1929
and that death occurred, on the date stated above, at 12.20 A m.
The CAUSE OF DEATH* was as follows:

Cerebral Trauma

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Instrumental delivery

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Blackfoot, Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms

(Signed) [signature] M. D.
June 19, 1929 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: June 17 1929

20. Undertaker: [illegible] Address: Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66502

PLACE OF DEATH
County of Bonneville
City of Ucon

Registration District No. 73
Primary Registration District No. 214-0
Local Registrar's No. 122

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Delbert Lot

(a) Residence. No. Ucon, Idaho St. 172
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 17 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) February 28, 1928

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	8	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ucon, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Franklin LeRoy Lot
11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)
12. MAIDEN NAME OF MOTHER Lillian Bills
13. BIRTHPLACE OF MOTHER (city or town) Tennessee
(State or Country)

14. Informant LeRoy Lot
(Address) Ucon, Idaho.

15. Filed 6 24, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——, 19—, to ——, 19—
that I last saw h— alive on —, 19—
and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
No medical attention.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [signature], M. D.
6/24, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ucon, Idaho	June 23 1929

20. Undertaker	Address
Jack A. Wood	Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1929
RECEIVED JAN 20 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66503

County of Bonneville. Registration District No. 73
City of Idaho Falls. Primary Registration District No. 2107
Local Registrar's No. 123
(No. L.D.S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emilio Guzman.

(a) Residence. No. 1009 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	Mexican	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 17, 1927

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	1	9	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake City Utah.

PARENTS

10. NAME OF FATHER E. Guzman.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico
12. MAIDEN NAME OF MOTHER Vincenta Beltran.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico

14. Informant E. Guzman.
(Address) Idaho Falls Ida

15. Filed 6/24, 1929 (Signature) Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 22 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to June 22, 1929
that I last saw him alive on June 22, 1929
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Bronchio pneumonia

(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Rheumatic Rickets
(duration) yrs. 9 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & X ray
(Signed) W. Ray Watts M. D.
June 24, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls.	June 24 1929.

20. Undertaker V. F. McHan. Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66504

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 127

177

2. FULL NAME Bertha Epstein
(a) Residence. No. 170 G St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of J. Epstein

6. DATE OF BIRTH (month, day and year) 1881

7. AGE: 48 Years | Months: Unknown | Days: | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Roumania

PARENTS
10. NAME OF FATHER: Solman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Roumania
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Roumania

14. Informant: Mr J. Epstein
(Address) 170 G. Street - Idaho Falls

15. Filed 6/27, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27, 1929, to June 27, 1929
that I last saw her alive on June 27, 1929
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:
Toxemia from bee Sting
..... (duration) ~~yrs.~~ ~~mos.~~ 2 hours ~~ds.~~

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) [signature], M. D.
June 27, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salt Lake City Utah | Date of Burial: June 1929

20. Undertaker: V. F. McHan | Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66505

PLACE OF DEATH

County of Bonneville

City of Idaho Falls.

Registration District No. 73

Primary Registration District No. 2140

Local Registrar's No. 124

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myrtle Iris Jephson.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 2 yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 17-1926

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
2	7	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Ida.

PARENTS

10. NAME OF FATHER Leslie Jephson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Zealand.

12. MAIDEN NAME OF MOTHER Selma Timm

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Elmore Wis

14. Informant Leslie Jephson
(Address) Coltman Ida.

15. Filed 6/29, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1929, to June 28, 1929 that I last saw her alive on ..... 19..... and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows: Epidemic Cerebro Spinal Meningitis

..... (duration) ..... yrs. ..... mos. 23 ds.

CONTRIBUTORY (Secondary) Same

..... (duration) ..... yrs. ..... mos. 23 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cerebro Spinal fluid + gram

(Signed) H. D. Wickliffe, M. D.

June 29, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: June 30 1929

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66506

PLACE OF DEATH

County of Bonneville.
City of Idaho Falls.
Registration District No. 3
Primary Registration District No. 2 [illegible]
(No. L.D.S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 126

2. FULL NAME James A. Muir.
(a) Residence. No. 274-2nd. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Muir.

6. DATE OF BIRTH (month, day and year) Feb. 6 - 1861

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
68	4	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stock Buyer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ontario Canada.

PARENTS

10. NAME OF FATHER William Muir
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland.
12. MAIDEN NAME OF MOTHER Katherine McGillivray
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Toronto Canada.

14. Informant Mrs Katherine Muir.
(Address) Idaho Falls Ida.

15. Filed July 2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to June 30, 1929
that I last saw him alive on June 30, 1929
and that death occurred, on the date stated above, at 10 05 P.m.
The CAUSE OF DEATH* was as follows:
Central Lemontage
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) As Stmd
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) [signature], M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida
Date of Burial: July 3 1929

20. Undertaker: V. F. McHan.
Address: V. F. McHan

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66508

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 72
(No. So. Holly Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jonas Ferris Meeker

(a) Residence. No. So. Holly Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

49

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mary H. Meeker

6. DATE OF BIRTH (month, day and year) June 12th 1854

7. AGE	Years	Months	Days	If LESS than 1 day,
	75	—	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER James Meeker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Cynthia Bates
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Mary H. Meeker
(Address) Nampa, Idaho

15. Filed 6/15, 1929 Lucretia Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to June 14, 1929, that I last saw h— alive on June 14, 1929, and that death occurred, on the date stated above, at 12:10 a.m.

The CAUSE OF DEATH* was as follows:
Septicemia following Amputation & Carcinoma of Tongue & Jaw at Bergum Mo. Caldwell Hospital
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cancer of Tongue
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) V C Bullock M. D.
June 15, 1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	6-16 1929

20. Undertaker	Address
Wm D. Talley	Nampa Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66509

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
(No. 3 miles west of Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 73

2. FULL NAME Francis Lemon
(a) Residence. No. 3 miles west St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) widowed

5a. ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ ~~(or) WIFE of~~

6. DATE OF BIRTH (month, day and year) Dec 6 - 1849

7. AGE Years 79 Months 6 Days 2 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Aledo Ill.

PARENTS
10. NAME OF FATHER Lock Lemon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Mrs Carl Smyth
(Address) RAD #1, Nampa Ida

15. Filed 6-10, 1929 Dutha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ___, 19___, to June 8, 1929
that I last saw him alive on June 5, 1929
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:
Paralysis
(duration) ___ yrs. ___ mos. 7 ds.
CONTRIBUTORY (Secondary) Degenerative Cardiovascular Disease
(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Geo R Frost M. D.
___, 19___ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kohlerlawn Cem
Date of Burial 6-10 1929

20. Undertaker F. K. Robinson
Address Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66510

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 74
(No. Nampa Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William B. Patten 117

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 5 - 1846

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
82	5	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer) (Retired)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER H. Patten
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa
12. MAIDEN NAME OF MOTHER Houk
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ga

14. Informant Mrs Basha Thompson
(Address) Florence, Colo.

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 —, 1929, to June 16, 1929
that I last saw h~~im~~ alive on June 15 —, 1929
and that death occurred, on the date stated above, at 1 a. m.
The CAUSE OF DEATH* was as follows:
Gangrenous Appendicitis
Strangulated Inguinal Hernia
(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Senility
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of June 13-29
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Samuel A Swayne, M. D.
June 15, 1929 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Ida	6-18 1929
20. Undertaker	Address
F.T. Robinson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66511

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 75

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lowie J. Ferrenburg. 31

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of X
(or) WIFE of X

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 52 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kentucky

PARENTS

10. NAME OF FATHER: G. P. Ferrenburg
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Mattie Bruner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: S. Ferrenburg
(Address) 1222 - 12 Ave South, Nampa

15. Filed 6/28, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to One visit, 19..., that I last saw him alive on June 26, 1929 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:
Pulmonary
Tuberculosis

..... (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Microscopic
(Signed) J H Murray, M. D.
June 28, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cem | Date of Burial: 6-30-1929

20. Undertaker: Fred R. Hinson | Address: Nampa

Murray

RECEIVED JUL 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66512

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 76

2. FULL NAME Margret Miles Smith

(a) Residence. No. 604 - 15 ave no ~~St.~~ 129
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) widowed

5a. If married, ~~widowed~~, or ~~divorced~~ ~~HUSBAND of~~ ~~(or)~~ WIFE ~~of~~ widowed B. J. Smith

6. DATE OF BIRTH (month, day and year) April 1 1857

7. AGE Years 72 Months 2 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pettston Penn

PARENTS

10. NAME OF FATHER Antony McNulty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Irland
12. MAIDEN NAME OF MOTHER Bridget Foy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Irland

14. Informant Mrs H. C. Bollard
(Address) Nampa Ida

15. Filed 6-27, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 20, 1929
that I last saw her alive on June 20, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Geo O. A. Kellogg, M. D.
6-27, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St Johns Ann Brise Ida — Date of Burial 6-27 1929

20. Undertaker Frank R Hinson — Address Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

K

FORM V. S. RECEIVED JUL 3 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 7004

(No. ....., ... St.)

File No. 66513

Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fannie Licklider

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec (Month) 8 (Day) 1873 (Year)

7. AGE: 55+ Yrs. 6 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Samuel Licklider

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sarra ~~Licklider~~ ~~Unknown~~ Clymer

13. BIRTHPLACE OF MOTHER (State or Country): ~~Missouri~~ Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. O. Poyute

(Address) Nampa

15. Filed 7/2 1929 Bertha Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1918, to June 27 1929 that I last saw her alive on June 27 1929 and that death occurred on the date stated above, at 9 20 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

..... (Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. O. Poyute M. D.

..... 19..... (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 11 yrs. 1 mos. 10 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn

DATE OF BURIAL: 6-29 1929

20. UNDERTAKER: Wm. D. Tabley

ADDRESS: Nampa

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66514

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 78
(No. 12th Ave & 3rd St. No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ira James Ames. 498

(a) Residence. No. 12th Ave & 3rd St. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Minnie Ames.

6. DATE OF BIRTH (month, day and year) Aug. 20th 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	10	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Common laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Clark Ames
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Fannie Berum
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant J. G. Ames.
(Address) Nampa, Idaho

15. Filed 7/2, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 10:00 P m.

The CAUSE OF DEATH* was as follows:
Myo-carditis
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) John A Bucy Acting Coroner M. D.
June 28 1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	7-2 1929
20. Undertaker	Address
Wm Talley	Nampa, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66515

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 7006
Local Registrar's No. 29
(No. Mercy Hosp)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Donald L. McCall

(a) Residence. No. McCall Ida
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 25-1915

7. AGE	Years	Months	Days	If LESS than 1 day,
	13	7	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Jr. school
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho

PARENTS

10. NAME OF FATHER L. D. McCall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cass Co. Mo
12. MAIDEN NAME OF MOTHER Emma M. McGee
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Portland Ore

14. Informant J D McCall
(Address) McCall Ida

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to June 24, 1929
that I last saw h[illegible] alive on June 24, 1929
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Rocky Mt. Spotted Fever
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Acute nephritis
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? McCall, Ida.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Samuel A Swayne, M. D.
July 2 1929 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fairview Cem	6-26 1929
Undertaker	Address
Fred K Pfost	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

K.

RECEIVED JUN 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66516

PLACE OF DEATH

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 44

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isabell C Wilson

(a) Residence. No. 10 "Y" Dearborn Caldwell Ida St. (Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 23-1855

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	11	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Mrs. W. L. Walker
(Address) 1222 Dearborn St. Caldwell Ida.

15. Filed 5-15-, 1929. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4, 1929 to May 13, 1929 that I last saw h[illegible] alive on May 13, 1929 and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Cecum
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) [signature], M. D.
5/15-, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Brookfield Mo.	
20. Undertaker C. F. Peckham	Address Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66517

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 45
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Theodore Dwight Harris 111a
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widower.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 11 - 1845

7. AGE: 83 Years, Months: 9, Days: 12. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter & Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): W. Virginia

PARENTS
10. NAME OF FATHER: James Harris
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Cora E. Wooley
(Address) cor 8th & Cleve Caldwell Idaho

15. Filed 5-24-, 1929. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20, 1929, to May 23, 1929
that I last saw him alive on May 22, 1929
and that death occurred, on the date stated above, at 8:15 a.m.
The CAUSE OF DEATH* was as follows:
Arterial Sclerosis
Alex Stamock
Duodenal
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) aya
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) V. D. Farrer, M. D.
May 23, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: May 24, 1929

20. Undertaker: C. V. Peckham
Address: Caldwell, Ida

RECEIVED JUN 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66518

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 46

(No. 101a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary S. Gowey

(a) Residence. No. Caldwell Ida R#1 St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of C. E. Gowey.

6. DATE OF BIRTH (month, day and year) Jan 27 - 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	3	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER J. David Sharp

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Amer Wells

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Willisburg Ohio.

14. Informant C E Gowey
(Address) Caldwell Ida R#1

15. Filed 5-27-, 1929. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 24, 1929, that I last saw h[illegible] alive on May 24, 1929, and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) 9 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) [signature], M. D.
5/25, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	5-27 1929
20. Undertaker C J Peckham	Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66519

PLACE OF DEATH

County of Canyon
City of Middleton.
Registration District No. 3
Primary Registration District No. 24
Local Registrar's No. 47
(No. Middleton, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Francis John Wade.

(a) Residence. No. Middleton, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) May 23rd 1929.

7. AGE Years	Months	Days	If LESS than 1 day, ---------- hrs. or min.
0	0	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Middleton, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER
Guy Wesdott Wade.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)
Creighton, Neb.

12. MAIDEN NAME OF MOTHER
Agnes Katherine Castle.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Garden Valley, Idaho.

14. Informant Mrs. Mary Ida Castle.
(Address)

15. Filed 6-6-, 1929 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 31st 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 23, 1929, to May 31, 1929, that I last saw h[illegible] alive on May 31, 1929, and that death occurred, on the date stated above, at 2:20 A.M.

The CAUSE OF DEATH* was as follows:
Injuries at Birth
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible], M. D.
19 (Address) Star, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	5/31/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Ida.

Jan 23/1929

RECEIVED JUN 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66520

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 48

2. FULL NAME Mary Jane McCoy Riggs 88a
(a) Residence. No. Wilder Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of E. H. Riggs

6. DATE OF BIRTH (month, day and year) Feb 28" 1903

7. AGE: Years 26 | Months 3 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bloomfield Okla.

PARENTS
10. NAME OF FATHER Martin McCoy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ca Woodsfield Ohio
12. MAIDEN NAME OF MOTHER Della Hartline
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Woodsfield Ohio

14. Informant Mart McCoy
(Address) Wilder Ida

15. Filed 6-6-, 1929 John S. Meyes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23, 1929, to June 5, 1929
that I last saw her alive on June 5, 1929
and that death occurred, on the date stated above, at 8:15 a.m.
The CAUSE OF DEATH* was as follows:
Septic endocarditis
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? symptoms
(Signed) [signature] M.D.
6/5, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: June 7 1929

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66521

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 9
Primary Registration District No. 1009
Local Registrar's No. 50
(No. 102)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Martha Elson

(a) Residence. No. 424 Arthur St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 7 1854

7. AGE	Years	Months	Days	If LESS than 1 day,
	74	7	- -	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ills

PARENTS
10. NAME OF FATHER Wm Cooper
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lexington Ky
12. MAIDEN NAME OF MOTHER Mary Job
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bainbridge Ind

14. Informant Sadie Evans
(Address) 424 Arthur

15. Filed 6-9-, 1929 John L. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 7-29
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to June 7, 1929
that I last saw her alive on June 7, 1929
and that death occurred, on the date stated above; at m.
The CAUSE OF DEATH* was as follows:
Pleurisy -
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) age -
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Clinical -
(Signed) J D Garver M. D.
, 19 (Address) Caldwell Ida -

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	June 9-29
20. Undertaker	**Address**
Paul L. Case	Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 11 1929 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66522

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 57
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Doe 1890

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unk

7. AGE	Years	Months	Days	If LESS than 1 day,
	45			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Nothing could be found to identify this man, his name or residence.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country)

14. Informant Paul L. Case
(Address) Caldwell Idaho

15. Filed 6-24-, 1929 John L. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Head crushed. Ac cidental.
Caused by sliding door in freight car of O S L Ry being suddenly closed catching man's head.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Paul L. Case M. D.
May 31-29, 19..... (Address) Coroner Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	May 31-29
20. Undertaker	**Address**
Paul L. Case	Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

YOUR HOME SHOULD COME FIRST

RECEIVED JUL 11 1929

PAUL L. CASE
IDAHO LICENSE E-199

STORES AT CALDWELL AND EMMETT, IDAHO

CASE FURNITURE COMPANY

Undertaking

FIRST STREET AND ELEVENTH AVENUE

~~NAMPA~~, IDAHO

Caldwell Idaho June 22-29

Dr Jno S Meyer
Cty
Dear Dr:

Suppose I should have turned this in sooner but was waiting to see if some identification might turn up or some rel ative so that I could get his real name and correct entries for the death certificate, but have been unsuccessful.

Sincerely

Paul L Case

RECEIVED JUL 1 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66523

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 53

PLACE OF DEATH

County of Canyon
City of Middleton
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Jordan Henry Moberly

(a) Residence. No. Middleton St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE~~ of Mrs. Salome Moberly

6. DATE OF BIRTH (month, day and year) Nov 28" 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	6	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Harness maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant L. M. Moberly
(Address) Middleton Idaho

15. Filed 6-15-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1928, to June 12, 1929
that I last saw him alive on the 12th of June, 1929
and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:
Cancer of Omentum
(duration) yrs. 9 mos. 12 ds.

CONTRIBUTORY (Secondary) nothing
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Salomon & patient

(Signed) J. W. Hamer, M. D.
June 15 1929 (Address) Middleton

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Middleton Idaho	June 15 1929
20. Undertaker O. L. Beckham	Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66524

PLACE OF DEATH
County of Canyon,
City of Caldwell, Idaho,
Registration District No. 8
Primary Registration District No. 1005
Local Registrar's No. 54
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Henry Harrison Schenck,
(a) Residence. No. Canyon Countu, Idaho, Rfr Rural St. No. 1.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Widowed,

5a. If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND of~~ (or) ~~WIFE of~~ Margaret Virginia Schenck,

6. DATE OF BIRTH (month, day and year) November, 19-1845,

7. AGE	Years	Months	Days	If LESS than 1 day,
	83	6	26	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Contracting Engineer,
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Vienna,
(State or country) New Jersey,

PARENTS

10. NAME OF FATHER John Schenck,
11. BIRTHPLACE OF FATHER (city or town) New Jersey,
(State or Country)
12. MAIDEN NAME OF MOTHER Elizabeth Luce,
13. BIRTHPLACE OF MOTHER (city or town) New Jersey,
(State or Country)

14. Informant John S Meyer
(Address) Caldwell Idaho

15. Filed 6-16-, 1929 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 1-29, 19, to June 15-29, 19
that I last saw him alive on June 15-29, 19
and that death occurred, on the date stated above, at 10 P M m.
The CAUSE OF DEATH* was as follows:
Hemorrage of head.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hardening of arteries.
and old age.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms -
(Signed) John S. Meyer, M. D.
June 16-29, 19 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	6-18-29 19
20. Undertaker	Address
Paul L Case	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66525

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 55
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Susanna Wilson

(a) Residence. No. Caldwell R#1 St. 101a
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 9-1845

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	9	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Carl Co. Ill.

PARENTS

10. NAME OF FATHER — Watson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Ann West
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) not known

14. Informant Mrs A Willson
(Address) Caldwell Idaho R#4

15. Filed 6-18-, 1929 John L. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 15, 1929
that I last saw h ee alive on June 15, 1929
and that death occurred, on the date stated above, at 8:30a m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) ——
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C D Frazer, M. D.
June 17, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	June 16 1929
20. Undertaker C. R. Peckham	Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 1005

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66526

Local Registrar's No. 56

2. FULL NAME Thomas S Jackson

(a) Residence. No. 16th & Bearborn St. 117

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 17 1875

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
53	11	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Atty at Law

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marcus Iowa

PARENTS

10. NAME OF FATHER Peter Jackson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Frances Reed

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant Mrs Alma Jackson

(Address) 16th & Dearborn

15. Filed 6-18-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15-29 19..

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to June 15, 1929

that I last saw him alive on June 15, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of June 10 24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) [signature], M. D.

6/17, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill

Date of Burial: June 18-29

20. Undertaker: Paul L. Case

Address: Caldwell Ida

Farver

RECEIVED JUL 11 1929

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 3

Registration District No.

Primary Registration District No. 2005

DO NOT WRITE IN THIS SPACE

State File No. 66527

Local Registrar's No. 59

(No. 101 B)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel A Armstrong

(a) Residence. No. (Ten Hos) St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Conductor - R. Ry.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10. NAME OF FATHER Henry clay Armstrong

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Georgia

14. Informant Harvey Turnbow

(Address) Kuston Ida R.D.

15. Filed 6-28- 1929. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1929 to June 28 1929
that I last saw h[illegible] alive on June 28 1929
and that death occurred, on the date stated above, at 12:05 P m.

The CAUSE OF DEATH was as follows Hypostatic Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C D Farver M. D.

June 28 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
El Reno, Okla	
20. Undertaker C. W. Peckham	Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66528

PLACE OF DEATH

County of Canyon
City of Caldwell,,

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 60

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard De Voe

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Grace De Voe

6. DATE OF BIRTH (month, day and year) Nov. 27-1869

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	7	2	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rancher

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Cape Britton Island Nova Scotia

PARENTS

10. NAME OF FATHER Peter De Voe

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Charlotte Reshor

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Richard De Voe
(Address) Caldwell, Ida

15. Filed 6-30-, 1929. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to June 28, 1929
that I last saw h[illegible] alive on June 20 1929
and that death occurred, on the date stated above, at 6 00 m.
The CAUSE OF DEATH* was as follows: Carcinoma (Face)

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? (Mayo Clinic)

(Signed) J S Francis M. D.
June 29, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	6-30 1929
20. Undertaker O. L. Case	Address
Case Furniture Co.	Caldwell Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66529

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 61

2. FULL NAME Nicholas Anthony Walsh
(a) Residence. No. Melba Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

196

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of single

6. DATE OF BIRTH (month, day and year) June 22, 1909

7. AGE Years 29 Months Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Electric operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Idaho Power Co.

9. BIRTHPLACE (city or town) (State or country) California

PARENTS
10. NAME OF FATHER Nicholas Walsh
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Mary Ella
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant F. X. Walsh
(Address) Melba Idaho

15. Filed 7-2-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 29 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to June 29, 1929
that I last saw him alive on ..... 19..
and that death occurred, on the date stated above, at 5:22 9 m.
The CAUSE OF DEATH was as follows: Electrocuted

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. M. Kaley, M. D.
7-1- 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kohler Lawn Nampa
Date of Burial 7-3 1929

20. Undertaker Paul L. Case Case Furniture Co
Address Caldwell, Ida

Dud

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 66530

Local Registrar's No. 62

2. FULL NAME Sylvester Greenfield 49

(a) Residence. No. 701 Fillmore St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Wid.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 21" 1856

7. AGE Years: 72 Months: 8 Days: 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ind.

PARENTS

10. NAME OF FATHER: Samuel Greenfield

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Mary Hardesty

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ind.

14. Informant: C C Greenfield
(Address) R2D Caldwell Ida

15. Filed 7-10-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 8" (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 6:55 a.m.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Age & Ch. Dental infection

(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. N. Dudley, M. D.

7/9, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: July 10 1929

20. Undertaker: C. V. Peckham — Address: Caldwell Ida

RECEIVED JUL 19 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

66530

Dr. S.B. Dudley

Caldwell, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

G. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

Sylvester Greenfield who died July 8, 1929.

Information DESIRED in order to complete certificate.

Was he single, married, widowed, or divorced?

PLEASE ANSWER BELOW

Widower

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66531

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15

2. FULL NAME Susannah May Ellis 46
(a) Residence. No. Soda Springs Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Ellis

6. DATE OF BIRTH (month, day and year) Nov. 19-1879

7. AGE Years 49 Months 6 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER John J. Trappett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Ladel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant George W Ellis
(Address) Soda Springs Ida

15. Filed 6-6-1929 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1928, to June 5, 1929
that I last saw her alive on June 5, 1929
and that death occurred, on the date stated above, at 7:20 A. m.
The CAUSE OF DEATH* was as follows:
Uterine Carcinoma
(duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) 0
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? No Date of 0
Was there an autopsy? No
What test confirmed diagnosis? Physical Ex
(Signed) Russell Tigert, M. D.
June 6, 1929 (Address) Soda Spgs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida — Date of Burial June 6-9-1929

20. Undertaker E. D. T. Pitterau — Address Soda Springs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66532

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14

186

2. FULL NAME Claude Ray Owens

(a) Residence. No. Conda Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lavere Owens

6. DATE OF BIRTH (month, day and year) Sept 8th 1894

7. AGE Years 34 Months 9 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) Phosphate Mines
(c) Name of employer C. C. Mr. Company

9. BIRTHPLACE (city or town) (State or country) Robleville Texas

PARENTS

10. NAME OF FATHER Frank Owens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bushnell, Ill
12. MAIDEN NAME OF MOTHER Lottie Cox
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dixon Kentucky

14. Informant Clyde C. Owens
(Address) Soda Springs Idaho

15. Filed July 2, 1929 Dr Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1929, to July 1, 1929
that I last saw him alive on July 1, 1929
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Trauma from a Premature Blast

..... (duration) ..... yrs. ..... mos. 6 hrs ds.

CONTRIBUTORY (Secondary) 0

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Conda, Ida
Did an operation precede death? yes Date of 7-1-29
Was there an autopsy? 0
What test confirmed diagnosis? —
(Signed) Eric Kaufman, M. D.
July 2, 1929 (Address) Soda Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Idaho — Date of Burial July 3 1929

20. Undertaker E. D. Whitman — Address Soda Springs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66533

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No. 539 – North Hansen.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Ruth Bavendale Carlson

(a) Residence. No. 539 – N. Hansen St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 24 – 1927

7. AGE Years 2 Months 5 Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Orlando Carlson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Margaret Bavendale
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Orlando Carlson
(Address) Burley Idaho

15. Filed 7-11-, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to July 1, 1929
that I last saw her alive on July 1, 1929
and that death occurred, on the date stated above, at 6:30 P. m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Erysipelas

(duration) yrs. mos. 16 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E. Dean, M. D.
July 1, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

RECEIVED JUL 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66534

PLACE OF DEATH

County of Cassia.
City of Burley.

Registration District No.
Primary Registration District No.
(No. Fremstad Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

Dean

41

2. FULL NAME Clarence Raymond Eastman.

(a) Residence. No. St. Moline. Illinois
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 25 - 1885

7. AGE Years 44 Months 4 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Auto. Mechanic.
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer Self.

9. BIRTHPLACE (city or town) (State or country) Moline. Illinois

PARENTS

10. NAME OF FATHER Justin Eastman.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cambridge. Illinois
12. MAIDEN NAME OF MOTHER Anna Fitzsimmons.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Limeridge Penn.

14. Informant Anna Eastman
(Address)

15. Filed July 11, 1929 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6/30/1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to June 30, 1929
that I last saw him alive on June 30, 1929
and that death occurred, on the date stated above, at 4:30 A m.
The CAUSE OF DEATH* was as follows:
Serous peritonitis
Following ruptured
Duodenal ulcer
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E. Dean, M. D.
, 19 (Address) Burley Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burley, Cemetery — Date of Burial: 7/2/29

20. Undertaker: D. C. Johnson — Address: Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66535

PLACE OF DEATH
County of Cassia
City of Burley.

Registration District No.
Primary Registration District No.
(No. 3 miles south of Burley.
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

Dr Dea

2. FULL NAME James Lamoni Watterson
(a) Residence. No. 3 miles South of Burley. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Watterson

6. DATE OF BIRTH (month, day and year) May 24 1874

7. AGE Years 55 Months 1 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER William Watterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Caroline Hobbs.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs. Caroline Watterson.
(Address) Burley, Idaho.

15. Filed Jul 21, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to June 27, 1929
that I last saw him alive on June 27, 1929
and that death occurred, on the date stated above, at 8:50 A.m.
The CAUSE OF DEATH* was as follows:
Ruptured Gastric Ulcer
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E. Lean, M. D.
June 28, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Idaho — Date of Burial 6/30/29

20. Undertaker D. E. Johnson — Address Burley.

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of James Lamoni Watterson

now lying buried in Burley City Cemetery, in the City or Town of Burley

County of Cassia State of Idaho, who died on the 27 day of June, 1929, Aged 55 years ____ months

____ days, the cause of death being Dr. H. E. Dean and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

Ruptured gastric ulcer attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private
private or railway conveyance

to Logan City Cemetery in the City or Town of Logan County of --

State of Utah to take effect upon the approval by the local board of health of the City, Town, or County of

Cassia it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 22nd day of June, A.D. 19 66.

Permit issued to:
Hall Mortuary
34 East Center St.
Logan, Utah

W. W. Benson
by _____
Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City,

Town or County of _____ State of Idaho, this _____ day of _____, 19___.

_____
Health Officer

FORM BH 56-019

RECEIVED JUL 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66536

PLACE OF DEATH
County of Cassia
City of Declo.

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 3 miles south of Declo)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Gottfried Kerbs.

(a) Residence. No. Residence south of Declo. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie Kerbs

6. DATE OF BIRTH (month, day and year) Dec 5th, 1848

7. AGE Years	Months	Days	If LESS than 1 day,
80	6	19	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10. NAME OF FATHER William Kerbs

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia.

14. Informant Gottfried Kerbs, Jr.
(Address) Declo, Idaho.

15. Filed Jul 11, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 25th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 10:30 AM.

The CAUSE OF DEATH* was as follows:

Senility.

No doctor called.

... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D.E.Johnson Coronor, M. D.
June 27, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Paul cemetery	6/27/29
20. Undertaker D.E. Johnson	Address Burley

Johnson

RECEIVED JUL 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66537

PLACE OF DEATH
County of Cassia
City of Jackson

Registration District No.
Primary Registration District No.
(No. 1 Mile from Jackson.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

29

2. FULL NAME Virgil Wm Wilson
(a) Residence. No. Jackson, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6. DATE OF BIRTH (month, day and year) April 6-1924

7. AGE Years 5 Months 2 Days 13. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) California

PARENTS
10. NAME OF FATHER Wm A. Wilson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Dessa Moncur
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs. Wm Wilson
(Address) Jackson Idaho.

15. Filed July 11, 1929 F. H. Carter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 18 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1929, to June 18 1929
that I last saw him alive on June 18, 1929
and that death occurred, on the date stated above, at 9:00 A.m.
The CAUSE OF DEATH* was as follows:
Tetanus. (Most probable source of entry from a squirrel bite about 2 wks previously
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Roland Frazier, M. D.
, 19 (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rupert Cemetery
Date of Burial: June 20 1929

20. Undertaker: D. E. Johnson
Address: Burley, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66540

PLACE OF DEATH
County of Cassia
City of Oakley

Registration District No. 120
Primary Registration District No. 2199
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

2. FULL NAME Hyrum Harrison Severe

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 6, 1852

7. AGE: Years 77 | Months 2 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grantsville Utah.

PARENTS
10. NAME OF FATHER Harrison Severe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Dorcus McBride
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Geo H. Severe
(Address) Oakley

15. Filed July 10, 1929 R. O. Nielson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to April 9, 1929
that I last saw him alive on April 9, 1929
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Rt. Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) None

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Place of Death
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Charles B. Beymer, M. D.
April 17, 1929 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Oakley Ida
Date of Burial: April 12 1929

20. Undertaker: D. E. Johnson
Address: Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66541

PLACE OF DEATH
County of Cassia
City of Oakley

Registration District No. 120
Primary Registration District No. 2199
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

101a

2. FULL NAME Gertrude Isabell Warr

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Warr

6. DATE OF BIRTH (month, day and year) Jan. 18, 1864

7. AGE Years 65 Months 2 Days 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Norton Tuttle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Helen Uttley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Wm Warr
(Address) Oakley Ida

15. Filed July 10, 1929 R. C. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1929, to April 17, 1929
that I last saw her alive on April 17, 1929
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:
Rt. Lobar Pneumonia
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Chr. Myocarditis - Hypertension
Chr. Interstitial Nephritis (duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of Death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Laboratory
(Signed) Charles B. Beymer, M. D.
April 19, 1929 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Oakley Ida — Date of Burial April 20 1929

20. Undertaker D. E. Johnson — Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66542

PLACE OF DEATH
County of Cassia
City of Oakley

Registration District No. 120
Primary Registration District No. 199
(No. Oakley, Idaho. (Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14

2. FULL NAME Rosine ~~Emma~~ Mary Shaw.
(a) Residence. No. Oakley Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

57

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H. Shaw.

6. DATE OF BIRTH (month, day and year) May 31-1836

7. AGE Years 73 Months — Days 30 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER Francis L. Valle.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Louise M. Pratt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Mrs. M. Jackson
(Address) Pocatello, Idaho

15. Filed July 10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13, 1929, to June 30, 1929
that I last saw her alive on June 30, 1929
and that death occurred, on the date stated above, at 2:25 P. m.
The CAUSE OF DEATH* was as follows:
Acute Pericarditis. Chronic Myocarditis.
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Primary Carcinoma Colon
Secondary Carcinoma Liver (duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of Death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Charles B. Beymer, M. D.
July 1, 1929 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Oakley Cemetery — Date of Burial July 2 1929

20. Undertaker D. E. Johnson — Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66543

Local Registrar's No.

PLACE OF DEATH

County of Cassia

City of Oakley

Registration District No. 120

Primary Registration District No. 2194

(No. 100 a)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME. Hal J Warr

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): June 20 1929.

7. AGE — Years | Months | Days: 16. | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Oakley Ida.

PARENTS

10. NAME OF FATHER: Kenneth Tuttle Warr

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Oakley Idaho.

12. MAIDEN NAME OF MOTHER: Rowena Jensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wyoming.

14. Informant: K S Warr

(Address) Oakley

15. Filed July 10, 1929. A T Olson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 6 1929

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to July 6, 1929, that I last saw him alive on July 6, 1929, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Charles B. Bowner, M. D.

July 7, 1929 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Marion Ida.	July 7 1929
20. Undertaker	Address
E E Johnson	Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1929

OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66544

PLACE OF DEATH
County of Cassia
City of Almo
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hannah Bell Bruesch

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: John J Bruesch

6. DATE OF BIRTH (month, day and year): July 12 1856

7. AGE — Years: 72 | Months: 10 | Days: 17 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Vermont

PARENTS

10. NAME OF FATHER: William R Johnston
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Lavina Bowles
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: J.J.Bruesch
(Address): Almo Idaho.

15. Filed 6/10/, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 29 1929
(Month) (Day) (19 Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1928, to May 29, 1929
that I last saw her alive on May 29, 1929
and that death occurred, on the date stated above, at 7: P. m.
The CAUSE OF DEATH* was as follows:
Cancer of Rectum
(duration) yrs. 11 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E Dean, M. D.
May 31, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Almo Idaho. | Date of Burial 19

20. Undertaker: D.E.Johnson | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66545

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Adelbert Cutler

(a) Residence. No. St. 179
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of ~~(or) WIFE~~ of Sarah Ann Cutler

6. DATE OF BIRTH (month, day and year) Oct. 3 1855

7. AGE Years 73 Months 7 Days 24 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS
10. NAME OF FATHER Green Cutler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Louisa Cutler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Sarah Ann Cutler
(Address) Burley Idaho.

15. Filed May 31, 1929 F H Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 27 (Month) 1929 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to May 27, 1929
that I last saw him alive on May 27, 1929
and that death occurred, on the date stated above, at 9:00 P.m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Hypertrophic Prostate
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E. Dean, M. D.
May 28, 19 (Address) Burley Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal North Ogden Utah
Date of Burial June 1 1929

20. Undertaker D.E. Johnson
Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66546

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Wilson Jenkins

44

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Lillie Jenkins.

6. DATE OF BIRTH (month, day and year) Sept. 27 1874

7. AGE Years 54 Months 8 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Goshen Utah

PARENTS

10. NAME OF FATHER Charles L Jenkins

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Mary Conover

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Provo Utah

14. Informant Nettie Elison
(Address) Oakley Idaho.

15. Filed 6/15, 1929 F H Culley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 27 (Month) 1929 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 27, 1929
that I last saw him alive on May 27, 1929
and that death occurred, on the date stated above, at 6:8 m.
The CAUSE OF DEATH* was as follows:
Cancer at head of Pancreas.
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical
(Signed) Hugh E Dean, M. D.
May 29, 1929 (Address) Burley Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Idaho
Date of Burial May 30 1929

20. Undertaker D.E. Johnson
Address Burley

RECEIVED JUN 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66548

PLACE OF DEATH
County of Minedoka
City of Rupert

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

196

2. FULL NAME William Joseph Koeplin

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth M Koeplin

6. DATE OF BIRTH (month, day and year) Oct. 30, 1884

7. AGE	Years	Months	Days	If LESS than 1 day,
	44	6	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Government

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS

10. NAME OF FATHER Philip Koeplin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Elizabeth Koeplin
(Address) Burley Ida.

15. Filed May 20, 1929 Fr H Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16th, 1929, to May 17th, 1929
that I last saw him alive on May 16th, 1929
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
Electric - Burn
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis?
(Signed) C. H. Cooper, M. D.
May 24, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida.	May 20 1929
20. Undertaker D. C. Johnson	Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66549

PLACE OF DEATH
County of Cassia
City of Oakley

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME Charles Wesley Bailey

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug. 11, 1843

7. AGE — Years: 85 | Months: 8 | Days: 23 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Bevan Penn.

PARENTS

10. NAME OF FATHER: Chas Baily
11. BIRTHPLACE OF FATHER (city or town) (State or Country):
12. MAIDEN NAME OF MOTHER: Jennie Whitlake
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14. Informant: Jacob C Kinney
(Address): Burley Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22, 1929, to May 3, 1929
that I last saw him alive on April 28, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
Chronic Interstitial Nephritis
(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place Death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Laboratory
(Signed) Charles B. Rayner, M. D.
May 3, 1929 (Address) Oakley, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Blackfoot Idaho — Date of Burial 19

20. Undertaker: E J Peck — Address: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66550

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2157

(No. Northern Idaho Sanitarium) 53

Local Registrar's No. 69

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ~~Mr~~ Harold Brown

(a) Residence. No. ..... St. Orofino - Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 10 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) August 19, 1901

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	1	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Grand Forks, North Dakota.

PARENTS

10. NAME OF FATHER George Brown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained

12. MAIDEN NAME OF MOTHER Edith Jennings

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed June 29, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to June 29, 1929, that I last saw him alive on June 28, 1929, and that death occurred, on the date stated above, at 4.15 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the intestines and peritoneum

1 (duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Mental deficiency following infantile paralysis (duration) 25 yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) John Irvine McKelway, M. D.

June 29, 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
N. Idaho Sanitarium Cemetery	July 1 1929
20. Undertaker	Address
F. A. Billberg, Hosp. Attdt.	Orofino - Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66551

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2107
Local Registrar's No. 65
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jessie M. Dove

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore A Dove

6. DATE OF BIRTH (month, day and year) Jan 13. 1899

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	5	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Harman W Va

PARENTS

10. NAME OF FATHER Daniel Cooper
11. BIRTHPLACE OF FATHER (city or town) (State or Country) W. Va.
12. MAIDEN NAME OF MOTHER Annie Harper
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) W Va

14. Informant Theodore A Dove
(Address) Orofino

15. Filed Jun 29, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-21, 1929, to 6-27, 1929
that I last saw h[illegible] alive on 6-27, 1929
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:
Puerperal Septicemia
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Pyelitis Ulcers Complicating
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? V
Did an operation precede death? no Date of V
Was there an autopsy? no
What test confirmed diagnosis? Symptoms, History
(Signed) Dr. D Robertson, M. D.
6-28, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Jun 30 1929

20. Undertaker W. D. Simon Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

PLACE OF DEATH

County of Clearwater

City of Ahsahka

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66552

Registration District No. 90

Primary Registration District No. 2187

Local Registrar's No. 67

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

99B

2. FULL NAME Donald Lee Bryant

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb. 1. 1929

7. AGE: Years | Months 4 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ida

PARENTS

10. NAME OF FATHER: Singleton Bryant

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Harrison Arkansas

12. MAIDEN NAME OF MOTHER: Lizzie Patty

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wabash Indiana

14. Informant: Singleton Bryant
(Address) Ahsahka

15. Filed Jan 24, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6th, 1929, to 6-21, 1929

that I last saw him alive on June 21st, 1929

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows: —

Probably Malnutrition - & Bronchitis = Since birth. Never healthy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? (?)

(Signed) J. F. Robertson, M. D.

6/23, 1929 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cavendish Ida | Date of Burial: June 24 1929

20. Undertaker: W. L. Pinson | Address: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66553

PLACE OF DEATH
County of Clearwater
City of Drojino

Registration District No. 90
Primary Registration District No. 2157
Local Registrar's No. 66

(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry M. Moody

(a) Residence. No. ..... St. Laprai, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ● yrs. ○ mos. 28 ds. How long in U. S., if of foreign birth? ● yrs. ● mos. ● ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Unascertained

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	?	?	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Unascertained

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER James Moody

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Unascertained

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Drojino - Idaho.

15. Filed June 15, 1929. W. L. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 28, 1929
that I last saw him alive on May 27 - 1929
and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Senile psychosis; Simple deterioration (duration) ? yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) John Lowell McElroy, M. D.

May 28, 1929 (Address) Drojino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Northern Idaho Sanitarium Cemetery	May 31 1929
20. Undertaker	Address
F. A. Billberg, Hospital Attaf.	Drojino - Idaho.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66554

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 65
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John E Creelman 90

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 2 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	11	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Camas Prairy R R Co

9. BIRTHPLACE (city or town) (State or country) Truro Nova Scotia

PARENTS

10. NAME OF FATHER Samuel Creelman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Halifax Nova Scotia
12. MAIDEN NAME OF MOTHER Maggie Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nova

14. Informant Samuel Creelman
(Address) Orofino % Mrs Clark

15. Filed Jun 15, 1929. W. A. Sloan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December, 1928, to June 13, 1929
that I last saw him alive on June 13, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Chronic Valvular disease of heart (mitral Stenosis).
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Observation

(Signed) O M Husted, M. D.
June 14, 1929 (Address) Orofino Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino	Jan 15. 1929

20. Undertaker W D Pinson
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66555

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187

Local Registrar's No. 64

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank J. Sisk

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Catheryon Sisk

6. DATE OF BIRTH (month, day and year) Dec 3 1874

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	7	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Wis

PARENTS

10. NAME OF FATHER Nock Sisk
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wis
12. MAIDEN NAME OF MOTHER Unkown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unkown

14. Informant Mrs Sisk
(Address) Orofino

15. Filed June 11, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1929, to June 10, 1929
that I last saw h.. alive on June 10, 1929
and that death occurred, on the date stated above, at 5.40 P.M.
The CAUSE OF DEATH* was as follows:

Diabetes mellitus
(duration) 7 yrs. mos. ds.
CONTRIBUTORY (Secondary) Gangrene foot
(duration) yrs. 6 mos. 0 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of 6/6/29
Was there an autopsy? Yes
What test confirmed diagnosis? Unique exam.
(Signed) P. C. Hopkins M. D.
6/10, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino	June 12 19

20. Undertaker W. A. Shaw — Address Orofino

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66556

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 9
Primary Registration District No. 2187

Local Registrar's No. 63

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harry J. Yocum

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) [redacted]

7. AGE

Years	Months	Days	If LESS than 1 day
61			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Forest Service
(c) Name of employer Clearwater Nat. Forest

9. BIRTHPLACE (city or town) (State or country) Huntingdon Pa.

PARENTS

10. NAME OF FATHER Silas Yocum
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Rachel Brenneman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa

14. Informant John N. Yocum
(Address) Pierce Ida

15. Filed 6/11, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1929, to June 10 1929
that I last saw him alive on June 10, 1929
and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:
Heart - probably
Paralysis & valvular
(duration) 12 yrs. mos. ds.
CONTRIBUTORY (Secondary) Carcinoma - Pylorus
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? his home
Did an operation precede death? no Date of .....
Was there an autopsy? yes
What test confirmed diagnosis? Post
(Signed) H. H. Robertson, M. D.
6/7, 1929 (Address) Orofino Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pierce Ida	Jun 13 19
20. Undertaker W. L. Pierce	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66557

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187

Local Registrar's No. 63

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gordon Haywood Deal

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 24 1909

7. AGE	Years	Months	Days	If LESS than 1 day,
	20		13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Moscow Ida

PARENTS

10. NAME OF FATHER Harry Deal
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wood Virginia
12. MAIDEN NAME OF MOTHER Helen Boe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Moscow Ida

14. Informant Esther Sewell
(Address) Orofino Idaho

15. Filed Jun 11, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7, 1929, to June 8, 1929
that I last saw him alive on June 8, 1929
and that death occurred, on the date stated above, at 8:30 a.m.
The CAUSE OF DEATH* was as follows:
Coast
Cirrhosis -
(duration) yrs. mos. 15 ds.
CONTRIBUTORY (Secondary) Renal question mic-
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? Yes
What test confirmed diagnosis? Symptoms
(Signed) W. F. Roberson, M. D.
6/10, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	Ida 19
20. Undertaker	Address
W. D. Pinson	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66558

PLACE OF DEATH

County of Custer

City of Mackay

Registration District No. 76

Primary Registration District No. 2153

Local Registrar's No. 114

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Rundall

(a) Residence. No. Mackay, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: wt

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Rundall

6. DATE OF BIRTH (month, day and year): Nov. 2, 1873

7. AGE: Years 56 Months 6 Days 15 If LESS than 1 day, ... hrs. or X min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: engineer

(b) General nature of industry, business, or establishment in which employed (or employer): X

(c) Name of employer: X

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: John Henry Rundall

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: Mrs Dorothy Pupil
(Address) 1623 Eldon St. Baker, Ore

15. Filed 5/18, 1929. Rose Nowacki
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

acute dilation of heart

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [signature] M. D.

5/18, 1929 (Address) Victory Wd

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Union Oregon

Date of Burial: 19

20. Undertaker: Theo. R. Garnier

Address: Mackay, Ida.

RECEIVED JUN 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66559

PLACE OF DEATH

County of Custer
City of Darlington
Registration District No. 76
Primary Registration District No. 2153
Local Registrar's No. 113
(No.) 1012
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles H. Olson

(a) Residence. No. Darlington, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. 17 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Hannah Ehn Olson

6. DATE OF BIRTH (month, day and year) Aug. 28. 1874

7. AGE	Years	Months	Days	If LESS than 1 day,
	55	8	14	X hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Jotenbury, Sweden

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Marie Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Hannah Olson
(Address) Darlington, Idaho

15. Filed June 15, 1929. Rose Norwood
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-12, 1929, to 5-13, 1929
that I last saw him alive on 5-13-29, 1929
and that death occurred, on the date stated above, at 2:16 P m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia Anemia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Conrad A Olson M. D.
, 19 (Address) Mackay Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mackay, Idaho	May 16 1929
20. Undertaker	Address
Geo. R. Garner	Mackay, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66560

PLACE OF DEATH
County of Custer
City of Mackay

Registration District No. 7 6
Primary Registration District No. 2153
Local Registrar's No. 112

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1924

2. FULL NAME Bruce Delane Smith

(a) Residence. No. Mackay Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	white	S.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 14 - 1924

7. AGE	Years	Months	Days	If LESS than 1 day,
	4	8		hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Sandy Utah

PARENTS

10. NAME OF FATHER Bruce V Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sanford Colorado
12. MAIDEN NAME OF MOTHER Mildred Pope
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vernal Utah

14. Informant Bruce U. Smith
(Address) Mackay - Idaho

15. Filed June 15, 1929 Nora Nowacki Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 - 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-12, 1929, to 5-12, 1929
that I last saw h alive on 19
and that death occurred, on the date stated above, at 6 P.M. m.

The CAUSE OF DEATH* was as follows:
Accidental Traumatism
automobile accident

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Conrad A B Jensen, M. D.
, 19 (Address) Mackay, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mackay, Idaho	May 14 1929
20. Undertaker	Address
Geo. P. Lannin	Mackay, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66561

PLACE OF DEATH

County of Custer
City of Challis

Registration District No. 108
Primary Registration District No. 2186
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 91

101A

2. FULL NAME Robert Robinson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1841

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
88	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) London, England.

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) London

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) London

14. Informant Ed C. Dalonzon
(Address) Challis, Idaho.

15. Filed June 29, 1929. Elma McKinney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to June 26, 1929
that I last saw him alive on June 23, 1929
and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

La Grippe Pneumonia

6 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

years (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. E. Kistler, M. D.

7/8, 1929 (Address) Challis Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Challis	June 27 1929

20. Undertaker Leo Garnier Address Challis Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66562

PLACE OF DEATH
County of Custer
City of Challis

Registration District No. 108
Primary Registration District No. 2186
Local Registrar's No. 90

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Royal Elwood Walker

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 11, 1929

7. AGE Years Months 1 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mountain Home, Ida

PARENTS

10. NAME OF FATHER Frank Elwood Walker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Gertrude Biswell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Springfield Ill.

14. Informant Mrs Gertrude Walker
(Address) Challis, Idaho

15. Filed June 7, 1929 Edna McKinney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 4:30 P.m.
The CAUSE OF DEATH* was as follows:
pneumonia
no doctor in
attendance (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
..... (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) No Doctor in attendance, M. D.
(Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Challis
Date of Burial April 27 1929

20. Undertaker Friends
Address Challis, Ida

FORM V. S. No. 5-25 RECEIVED JUL 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Mt. Home Ida.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34

Primary Registration District No. 2820

(No. ..... , ... St.)

File No. 66563

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Barber - (Infant)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June (Month) 13 (Day) 1929 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Claud Barber.

11. BIRTHPLACE OF FATHER (State or Country): Colorado.

12. MAIDEN NAME OF MOTHER: Katie Larranen

13. BIRTHPLACE OF MOTHER (State or Country): Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Claud Barber.

(Address) Bruneau, Idaho.

15. Filed July 2 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13 (Day) 1929 (Year) 161a

17. I HEREBY CERTIFY, That I attended deceased from 6-13-1929, to 6-13-1929, that I last saw her alive on 6-13-1929, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Premature, 7 months

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. E. Evans M. D.

6-20 1929 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home

DATE OF BURIAL: 6-15 1929

20. UNDERTAKER: G. S. Zacher

ADDRESS: Mt Home

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

174024 N

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUL 12 1929

1. PLACE OF DEATH — Registration District No. 34
County of Elmore — Primary Registration District No. 2020
City of Mt Home — (No. ..... St.)
File No. 6056
Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caroline Elizabeth Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Married

6. DATE OF BIRTH — Feb (Month) 6 (Day) 1867 (Year)

6

7. AGE — 62 Yrs. 2 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Carson City, Nev.

10. NAME OF FATHER Trapp.

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) 11

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willis Johnson
(Address) Mt Home

15. Filed July 2 1929 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — April (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-1-1928 to 4-23-1929 that I last saw h[illegible] alive on 4-23-1929 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H E Evans M. D.
5-10-1929 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~ — Mountain Home — DATE OF BURIAL 4-24-1929

20. UNDERTAKER G. S. Zaeker — ADDRESS Mt Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JUL 12 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Elmore

City of Mountain Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34

Primary Registration District No. 2020

(No. ..... St.)

State File No. 66566

Local Registrar's No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert ~~Poirer~~ Poirer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7. AGE: About 78 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF Father —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed June 18 1929 A. F. Anderson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH About 193? (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to ..... 19 ....., that I last saw h..... alive on ..... 19 ....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Exposure to elements.
Body found 15½ miles west of Mountain Home

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Grant E. Hughes Coroner M. D.

..... 19 ..... (Address) Glenns Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Mountain Home

DATE OF BURIAL: April 30 1929

20. UNDERTAKER: G. S. Zacher

ADDRESS: Mt Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M-1-19 RECEIVED JUL 8 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Franklin

City of Fairview

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St.)

State File No. 66567

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ann Jones Haslam

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH: August 7th. 1848 (Month) (Day) 1 (Year)

7. AGE: 80 Yrs. 9 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer) At Home

9. BIRTHPLACE (State or Country) Birkennett, England

10. NAME OF Father Joseph Jones

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Jane Parry

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John J. Haslam
(Address) Wellsville, Utah

15. Filed ..... 19 ..... A. R. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 2nd. 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 7" 1929, to May 2" 1929, that I last saw her alive on May 2" 1929, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: General Debility

(Duration) several yrs. mos. ds.

Contributory (Secondary) Old age

(Duration) yrs. mos. ds.

(Signed) H. K. Merrill M. D.

June 4 1929 (Address) Logan Ut.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 14 days. In the State ..... yrs. ..... mos. 14 ds.
Where was disease contracted if not at place of death?
Former or usual residence Wellsville, Utah

19. PLACE OF BURIAL OR REMOVAL: Wellsville, Utah

DATE OF BURIAL 1929

20. UNDERTAKER: [signature]

ADDRESS Logan

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66568

PLACE OF DEATH

County of Franklin

City of Franklin

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Zina Lavon Nelson

1000

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): May 10 1929

7. AGE: Years | Months | Days: 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Franklin Idaho

PARENTS

10. NAME OF FATHER: Carl N. Nelson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sandy Utah

12. MAIDEN NAME OF MOTHER: Rea Blanch Albiston

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Franklin Idaho

14. Informant: Carl N. Nelson
(Address): Franklin Idaho

15. Filed April 9, 1929 C. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. 7 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr-5- 1929, to Apr 7- 1929,
that I last saw h alive on Apr 7 1929
and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(duration) — yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) G. W. States, M. D.
Apr. 8 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Franklin Idaho	May 8 1929

20. Undertaker: M. W. Hendricks Address: Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHY... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of C... TION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

County of .....

City of Franklin Idaho Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harriett Gibson

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and

Length of residence in city or town where death occurred. ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Gibson

6. DATE OF BIRTH (month, day and year) Nov II 1859

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	7	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Lihi Utah

PARENTS

10. NAME OF FATHER John Wolf

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Sarah Devoe

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N Y .

14. Informant Gibson

(Address) Franklin Id...

15. Filed ....., 19..... ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June — 14 —

(Month) (Day)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1928 to June 14

that I last saw her alive on June 18

and that death occurred, on the date stated above, at 6 —

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

..... (duration) 2 yrs., — mo

CONTRIBUTORY (Secondary) General debility

..... (duration) 3 yrs. ..... mo

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. W. States

June 15, 1929 (Address) Preston

*State the DISEASE CAUSING DEATH, or in deaths from ... CAUSES, state (1) MEANS AND NATURE OF INJUR... and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hyde Park Utah Date of Burial: June 15 29

20. Undertaker: M. W. Hendricks Address: Preston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66570

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

189

2. FULL NAME Willard Gailey

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Addie T. Gailey

6. DATE OF BIRTH (month, day and year): May 15 1867

7. AGE: 62 Years, Months: 1, Days: 10. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kaseville Utah

PARENTS

10. NAME OF FATHER: John Gailey
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Elizabeth T. Henwood
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs Willard Gailey
(Address) Fairview Idaho

15. Filed June 27, 1929 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-24, 1929, to 6-24, 1929
that I last saw him alive on 6-24, 1929
and that death occurred, on the date stated above, at 8:30 p.m.
The CAUSE OF DEATH* was as follows:
Shock from rupture of stomach (kicked by horse) and operation for repair.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. R. Cutler Jr., M. D.
6-27, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fairview Idaho
Date of Burial: 19

20. Undertaker: M. W. Hendricks
Address: Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66571

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.) 145

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Geo Bench

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Leah Bench

6. DATE OF BIRTH (month, day and year) Dec 23 1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	5	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Janiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) England
(State or country)

PARENTS

10. NAME OF FATHER John Bench

11. BIRTHPLACE OF FATHER (city or town) England
(State or Country)

12. MAIDEN NAME OF MOTHER Martha Baugh

13. BIRTHPLACE OF MOTHER (city or town) England
(State or Country)

14. Informant John Bench
(Address) Preston

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7, 1929, to June 11, 1929
that I last saw h.m. alive on June 11, 1929
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Ilious paralytic following Operation to Reduce a ventral Hernia injured by accident
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) He fell over a bench
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. R. Curtis, M. D.

June 13, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Logan Utah	June 16 19
20. Undertaker M. Hendricks	Address

RECEIVED JUL 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66572

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Rachel Della Ann Eaklesen

(a) Residence. No. St. 124
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Christensen Eaklesen

6. DATE OF BIRTH (month, day and year): May 23 1886

7. AGE: 43 Years, 1 Months, 28 Days. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): House wife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Minkcreek Idaho

PARENTS

10. NAME OF FATHER: Peter T. Petersen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Anna Larsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Nelse Christensen Eaklesen
(Address): Minkcreek Idaho

15. Filed , 19 . A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-1-, 1929, to 6-26, 1929
that I last saw her alive on 6-26 1929
and that death occurred, on the date stated above, at 1:15 a.m.
The CAUSE OF DEATH* was as follows:
Peritonitis postoperative following gastroenterostomy
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. R. Cutler M. D.
6-27, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Minkcreek Idaho
Date of Burial: June 30 1929

20. Undertaker: M.W.Hendricks
Address: Preston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66573

PLACE OF DEATH
County of Franklin
City of Preston Ida

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 162)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leslie Nimn

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6. DATE OF BIRTH (month, day and year)

7. AGE — Years | Months | Days | If LESS than 1 day, 2 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Preston Ida

PARENTS

10. NAME OF FATHER Heber E Nimn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Preston Ida
12. MAIDEN NAME OF MOTHER Nora Mecham
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Riverdale Ida

14. Informant Heber Nimn
(Address)

15. Filed June 19, 1929 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/14, 1929, to 6/14, 1929
that I last saw him alive on 6/14, 1929
and that death occurred, on the date stated above, at 7 30 P m.
The CAUSE OF DEATH* was as follows:
Heart Failure
(Infant lived only 2 hours)
(duration) yrs. mos. ds.
CONTRIBUTORY ✓
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Thos B Holden, M. D.
6/14, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Prestons Ida — Date of Burial: June 1929
20. Undertaker: M. W. Henderickes — Address: Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66574

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 373)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Esther J. Campbell.
(a) Residence. No. June 7th Emmett Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of John D. Campbell.

6. DATE OF BIRTH (month, day and year) April 13th 1846

7. AGE	Years	Months	Days	If LESS than 1 day,
	83	April	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER Edwin Powell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Elizabeth Houck
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant E. D. Campbell
(Address)

15. Filed 6/10, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from for several years to June 7, 1929
that I last saw her alive on June 4th, 1929
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:
Myocardial insufficiency

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Pulmonary Tuberculosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? several years duration
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. L. Reynolds, M. D.
(Address) Emmett Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverside Cemetary	June 9, 1929

20. Undertaker C. D. Bucknum Address Emmett Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66575

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marion Juanita Denton

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: child

6. DATE OF BIRTH (month, day and year): Mar 11 - 1920

7. AGE: Years: 9 | Months: 3 | Days: 11 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Emmett Idaho

PARENTS

10. NAME OF FATHER: D H Denton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tennessee
12. MAIDEN NAME OF MOTHER: Eleonora Lenter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: D H Denton
(Address): Emmett Idaho

15. Filed 6/27, 1929 J K Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 26 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to June 26, 1929
that I last saw her alive on June 25, 1929
and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:
Peritonitis, Streptococic in Nature, probably caused by ruptured appendix
(duration) yrs. mos. ds.
General Streptococcic Septicemia
CONTRIBUTORY (Secondary)
(duration) yrs. mos. 12 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 6/20/29
Was there an autopsy? no
What test confirmed diagnosis? Abdomen opened and tube put in
(Signed) , M. D.
6/27, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Ida — Date of Burial: 6/28 1929
20. Undertaker: O Buckner — Address: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66576

PLACE OF DEATH

County of Kootenai
City of New Plymouth
Registration District No. 5
Primary Registration District No. 2009
Local Registrar's No. 2
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace Leone Robinson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	W.	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) April 10 - 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
		1	28	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) New Plymouth R D (State or country) Ida

PARENTS

10. NAME OF FATHER Jay Robinson

11. BIRTHPLACE OF FATHER (city or town) Montpelier Ida (State or Country)

12. MAIDEN NAME OF MOTHER Grace Lerwill

13. BIRTHPLACE OF MOTHER (city or town) Payson, Utah (State or Country)

14. Informant Mrs Jay Robinson
(Address) New Plymouth Ida

15. Filed June 12, 1929. Wm J. Drysdale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4th, 1929, to June 7, 1929
that I last saw her alive on June 7, 1929
and that death occurred, on the date stated above, at 5:25 P. m.

The CAUSE OF DEATH* was as follows:
General septicemia from infection of breast

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Nervousness upper area

(duration) ..... yrs. 1 mos. 28 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Wm J Drysdale, M. D.

6-12, 1929 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Emmett Idaho	6-8 1929

20. Undertaker	Address
Father & Child	New Plymouth Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUL 3 1929

1. PLACE OF DEATH — Registration District No. 21
County of Gooding — Primary Registration District No.
City of Hagerman (No. ..... St.) — File No. 66581
Registered No.
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Ruby Thompson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 19 (Day) 1900 (Year)

7. AGE: 49 Yrs. 5 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Allen

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Brenetta Mallen Hickman

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ruby Isaac
(Address) Caldwell Ida

15. Filed Jan 3 1929 — R H Greene, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1928, to Jan 2 1929, that I last saw h~~er~~ alive on Jan 2 1929 and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows: Cerebra Spinal Meningitis
(Duration) 4 Days
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R H Greene M. D.
19..... (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: R H Hagerman — DATE OF BURIAL: Jan 3 1929
20. UNDERTAKER: A C Thompson — ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 3 1929

CERTIFICATE OF DEATH

Registration District No. 21

Primary Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66582

Registered No.

1. PLACE OF DEATH

County of Gooding

City of Hagerman

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Jake Sevey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 19 (Day) 1929 (Year)

7. AGE: 61 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lorain Sevey

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Mary Weight

13. BIRTHPLACE OF MOTHER (State or Country): Calif

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leslie E. Sevey

(Address) Hagerman Idaho

15.

Filed 19

R H Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11 1929, to April 19 1929, that I last saw h alive on April 19 1929, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema
Following Apoplexy

(Duration) 6 Yrs. — mos. — ds.

Contributory (Secondary) Apoplexy

(Duration) yrs. mos. ds.

(Signed) L. L. Wainwright M. D.

April 20 (Address) Buhl Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hagerman

DATE OF BURIAL: Apr 21 1929

20. UNDERTAKER: [illegible]

ADDRESS: [illegible]

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 3 1929

CERTIFICATE OF DEATH

Registration District No. 21

Primary Registration District No. ____

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66583

Registered No. ____

1. PLACE OF DEATH
County of Gooding
City of Hagerman (No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph F Parrott
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: April (Month) 29 (Day) 1888 (Year)

7. AGE: 40 Yrs. 9 Mos. 15 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm Parrott

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Christina Stevens

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) His wife
(Address) Hagerman

15. Filed Feb 26 1929 — R N Greene, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1929, to Feb 16 1929, that I last saw h... alive on Feb 15 1929, and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:

About 4 days
Cerebro Spinal Meningitis
(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) R N Greene M. D.
19____ (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Hagerman — DATE OF BURIAL: Feb 17 1929

20. UNDERTAKER: Johnson — ADDRESS: Buhl

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 66584
Registered No.

RECEIVED JUL 3 1929

1. PLACE OF DEATH
Registration District No. 21
County of Gooding
Primary Registration District No.
City of Hagerman (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gladys Ellis.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant
6. DATE OF BIRTH: Mar (Month) 23 (Day) 1929 (Year)
7. AGE: Yrs. 5 Mos. weeks 0 ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Hagerman
10. NAME OF FATHER: L J Ellis
11. BIRTHPLACE OF FATHER (State or Country): Ida
12. MAIDEN NAME OF MOTHER: Edmina Smith
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L J Ellis
(Address) Hagerman
15. Filed Mar 28 1929 R H Greene Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1929, to Mar 22 1929, that I last saw h[illegible] alive on Mar 22 1929, and that death occurred on the date stated above, at 7 a. M.
The CAUSE OF DEATH* was as follows: Whooping Cough & Cold
2 days sick (Duration)
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) R H Greene M. D.
Mar 28 1929 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hagerman — DATE OF BURIAL: Mar 28 1929

20. UNDERTAKER: None — ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 3 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Hagerman

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No.

(No. ..... St.)

File No. 66585

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Nelson Cuff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June (Month) 7 (Day) 1929 (Year)

7. AGE: 5 hours Yrs. Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Hagerman Ida

10. NAME OF FATHER: Floyd Cuff

11. BIRTHPLACE OF FATHER (State or Country): S.D.

12. MAIDEN NAME OF MOTHER: Mae Dudley

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Floyd Cuff

(Address) Hagerman

15. Filed June 20 1929

R H Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8 (Day) 1929 (Year)

161a

17. I HEREBY CERTIFY, That I attended deceased from June 7 1929, to 9 PM to June 8 1929 that I last saw him alive on June 8 2 a.m. and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth.

Account Puerperal

(Duration) Yrs. mos. ds.

Contributory (Secondary) Seizures with convulsions

(Duration) 7 Mother yrs. mos. ds.

(Signed) R H Greene M. D.

19 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hagerman

DATE OF BURIAL: June 8 1929

20. UNDERTAKER: None

ADDRESS

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. RECEIVED JUL 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66586

Registered No.

Registration District No. 21

Primary Registration District No.

1. PLACE OF DEATH

County of Gooding

City of Wagerman (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Norman Christensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Nov (Month) 19 (Day) 1919 (Year)

7. AGE: Yrs. 9 Mos. 4 ds. 15

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charley Christensen

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Elva Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charley Christensen
(Address) Wendell

15. Filed Apr 6 1929 R. H. Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 2 1929, to Apr 3 1929, that I last saw him alive on Apr 3 1929, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

3 or 4 day. (Duration) Yrs. mos. ds.

Contributory (Secondary) Flu — (Duration) yrs. mos. ds.

(Signed) R. H. Greene M. D.

Apr 3 1929 (Address) Wagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wendell — DATE OF BURIAL: Apr 4 1929

20. UNDERTAKER: None — ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 3 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No.
File No. 66587
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Hagerman
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret A Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 22 (Day) 1873 (Year)

7. AGE: 55 Yrs. 6 Mos. 18 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Leonard C Lewis

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Mary Jane Woods

13. BIRTHPLACE OF MOTHER (State or Country): Louisiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J A Johnson
(Address) Hagerman

15. Filed Apr 16 1929 R H Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1929, to April 15 1929, that I last saw her alive on April 15 1929, and that death occurred on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 11 ds.
Contributory (Secondary) Pneumonia
(Duration) yrs. mos. ds.

(Signed) R H Greene M. D.
Apr 16 1929 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: E A Johnson Hagerman
DATE OF BURIAL: Apr 1929

20. UNDERTAKER: Johnson
ADDRESS: Buhl

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 3 19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21

Primary Registration District No.

File No. 66588

Registered No.

1. PLACE OF DEATH
County of Gooding
City of Wagenman
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Jane Bell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 7 (Day) 1926 (Year)

7. AGE: 3 Yrs. 3 Mos. 26 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Glen C Bell

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Lottie Thatcher

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leo V Bell
(Address) Wagenman

15. Filed May 3 1929 R H Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on May 3 1929,
and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr Simonton M. D.

19..... (Address) Wendell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wagenman — DATE OF BURIAL: May 4 1929

20. UNDERTAKER: E A Johnson — ADDRESS: Buhl

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66590

PLACE OF DEATH

CERTIFICATE OF DEATH

County of .....
City of .....
Registration District No. .....
Primary Registration District No. .....
(No. Gooding County Hospital)
Local Registrar's No. .....
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Leola Peck

(a) Residence. No. 117 Shoshone St. Idaho
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of S

6 DATE OF BIRTH (month, day and year) July 10 - 1913

7 AGE: Years 15 | Months 11 | Days 19 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Shoshone Idaho

PARENTS

10 NAME OF FATHER Samuel R Peck
11 BIRTHPLACE OF FATHER (city or town) (State or country) Idaho
12 MAIDEN NAME OF MOTHER Pearl Cooley
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Shoshone Ida

14 Informant Samuel R Peck
(Address) .....

15 Filed 6/30, 1929 J H Cromwell
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 29 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to June 29, 1929, that I last saw her alive on June 28, 1929, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:
Appendicitis
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Peritonitis
(duration) — yrs. — mos. 18 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of June 15 1929
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Cattrell Weaver M. D.
July 1, 1929 (Address) Gooding Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 RECEIVED JUL 5 1929 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66591

Registered No. 100

1. PLACE OF DEATH

County of Gooding

City of "

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 24

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ed Turner

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dont Know (Month) 1 (Day) (Year)

7. AGE: Dont Know about 60 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farming

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dont Know

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J H Cromwell

(Address) Gooding Ida

15. Filed 6/30 1929 J H Cromwell Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 1a

June (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1929 to June 26 1929 that I last saw h alive on June 26 1929 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Aortic aneurism

(Duration) 7 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J H Cromwell M. D.

1929 (Address) Gooding

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida

DATE OF BURIAL: 6/27 1929

20. UNDERTAKER: A E Thompson

ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66592

PLACE OF DEATH

County of Gooding
City of Wendell

Registration District No.
Primary Registration District No. 18-1
Local Registrar's No.

(No. St Valentines Home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

99a

2. FULL NAME Mrs Ellen Maher

(a) Residence. No. Wendell Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of William H Maher

6. DATE OF BIRTH (month, day and year) Aug 10 1842

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86	9	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housework
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Not Obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Obtainable
12. MAIDEN NAME OF MOTHER Not Obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Obtainable

14. Informant Ambrose A Maher
(Address) Eclipse Ida.

15. Filed 7/6 1929 C. F. Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 4, 1929
that I last saw her alive on June 4, 1929
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:
Acute Bronchytis
Cardiac failure
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. F. Zeller, M. D.
7/6, 1929 (Address) Jerome, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Jordan Valley Ore	
20. Undertaker	Address
Schreiber & McCann	Boise Ida

RECEIVED JUL 12 1929

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

File No. 66593

City of

(No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dr Hassard Alexander Purdy

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 5 (Day) 1857 (Year)

7. AGE: 71 yrs. 11 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dentist
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ontario Canada

10. NAME OF FATHER: William Purdy

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Margaret Thurston

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lottie A Purdy

(Address) Wendell Idaho

15.

Filed ..... 191 .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 25 (Day) 1929 (Year) 127

17. I HEREBY CERTIFY, That I attended deceased from June 12 191 to June 25 1929, that I last saw her alive on Jun 25 1929, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F. Schmershall M. D.

Jun 25 1929 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hagerman Idaho

DATE OF BURIAL: June 26 1929

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12 RECEIVED JUL 12 1929 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Gooding

City of Wendell

Registration District No.

Primary Registration District No.

(No. , St.)

File No. 66594

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Morris E. Huff

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: March (Month) 28 (Day) 1876 (Year)

7. AGE: 53 yrs. 2 mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Justus Eugene Huff

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Sarah Moreland

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A F Redman

(Address) Boise Idaho Lead and Ida Bertha Mallory

15. Idaho Power Co

Filed ..... 191 .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1929, to June 24 1929, that I last saw him alive on June 24 1929 and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Zeller M. D.

6/25 1929 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Olympia Wash

DATE OF BURIAL 191

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A-25M-1-19

RECEIVED JUL 15 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66595

Local Registrar's No.

1. PLACE OF DEATH

County of Idaho

City of Woodland

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2478

Primary Registration District No. 49

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliza George

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH: June (Month) 6 (Day) 1842 (Year)

7. AGE: 85 Yrs. 11 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF Father: Joseph Bentley

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. A. George

(Address) Woodland Ida

15. Filed 5/20 1929 [signature] Acting Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1929 (Year) 205a

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...., that I last saw h..... alive on ..... 19...., and that death occurred on the date stated above, at 12:29 M.

The CAUSE OF DEATH* was as follows:

Doctor in attendance

(Duration) ..... yrs. ..... mos. ..... ds.

No Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodland, Ida

DATE OF BURIAL: 5/20 1929

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 66596
Registered No. 10

1. PLACE OF DEATH
County of Ida
City of Cottonwood
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred M. Duclos

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 19 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Dominic Duclos

11. BIRTHPLACE OF FATHER (State or Country): South Do.

12. MAIDEN NAME OF MOTHER: Marie G. Suchtefeld

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dominic Duclos
(Address) Cottonwood, Idaho

15. Filed June 20 1929 W. F. Orr D.B. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1929, to June 19 1929, that I last saw him alive on June 19 1929, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Failure of Foramen Ovale to close.

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ashley Orr M. D.
6/20 1929 (Address) Cottonwood Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood — DATE OF BURIAL: 6-26 1929

20. UNDERTAKER: A. A. May — ADDRESS: Cottonwood, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Cottonwood

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105

Primary Registration District No. 2183

(No. ..... St.)

File No. 66597

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John W. Fain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 21 (Day) 1857 (Year)

7. AGE: 69 Yrs. 7 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ken

10. NAME OF FATHER: James F Fain

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Susien Ragsdale

13. BIRTHPLACE OF MOTHER (State or Country): Ken

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Ada M Fain

(Address) Sewiston Ida

15. Filed June 17 1929 W. F. Orr I. B. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 17 (Day) 1929 (Year) 100a

17. I HEREBY CERTIFY, That I attended deceased from June 16 1929, to June 17th 1929, that I last saw him alive on Jun 17 1929, and that death occurred on the date stated above, at 3:10 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. A. Woodcock M. D.

6-17-1929 (Address) Cottonwood Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sewiston, Idaho

DATE OF BURIAL: 6/19 1929

20. UNDERTAKER: Brower + Wann

ADDRESS: Sewiston, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. N[illegible]-25M. 1-19

RECEIVED JUN 18 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66598

Local Registrar's No. 276

1. PLACE OF DEATH

County of Idaho

City of Clearwater

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106

Primary Registration District No. 2184

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kenneth Georg Wasmundt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: May (Month) 15 (Day) 1927 (Year)

7. AGE: 2 Yrs. ..... Mos. 3 ds. .....

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho County

10. NAME OF Father: Fred Wasmundt

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Charlotte Peyton

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Wasmundt

(Address) Clearwater - Idaho

15. Filed May 19 1929 J. M. Underkuffler

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929 to May 18 1929, that I last saw him alive on May 16 1929 and that death occurred on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

.....

.....

.....(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Underkuffler M. D.

May 19 1929 (Address) Kooskia - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harpster — DATE OF BURIAL: May 19 1929

20. UNDERTAKER: Geo. Treuary — ADDRESS: Kooskia Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19

RECEIVED JUN 18 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Idaho

City of Kooskia

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106

Primary Registration District No. 2184

(No. ..... St.)

State File No. 66599

Local Registrar's No. 275

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Addie Laura Munro.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Jan (Month) 18 (Day) 1902 (Year)

7. AGE: 27 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Kooskia

10. NAME OF Father: Norman Lyons

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER: Addie Kidder

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. J. Munro.

(Address) Kooskia

15. Filed May 9 1929 J M Verbeekmans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1929 (Year) 101a

17. I HEREBY CERTIFY, That I attended deceased from April 25 1929, to May 6 1929, that I last saw her alive on May 6 1929 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Verbeekmans M. D.

May 9 1929 (Address) Kooskia Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kooskia - Idaho

DATE OF BURIAL: May 9 1929

20. UNDERTAKER: Geo Freeney

ADDRESS: Kooskia

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66600

PLACE OF DEATH
County of Idaho
City of near Whitebird
Registration District No.
Primary Registration District No.
(No. near Whitebird)
Local Registrar's No. 17
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Cornwell.

(a) Residence. No. near Whitebird St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

1899

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Andrew Cornwell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant D. A. Burdin
(Address) Whitebird Ida.

15. Filed 7-1-, 1929 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 19 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Accidental Crushed — Rock slide on Fiddle Creek near Riggins Ida.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida.	4-23-1929
20. Undertaker	Address
Jessup Mtd. Co.	Lewiston Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66601

PLACE OF DEATH
County of Idaho
City of Cottonwood

Registration District No. 96
Primary Registration District No. 1009

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

20-A

2. FULL NAME John W. Fain

(a) Residence. No. Lewiston St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 25, 1869

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	8	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ky.

PARENTS

10. NAME OF FATHER Jas. F. Fain
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Susan Ragsdale
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ky.

14. Informant Ida. M. Fain
(Address) Lewiston, Ida.

15. Filed July 1, 1929 Ervin G Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.
The CAUSE OF DEATH* was as follows:

.....(duration) .....yrs. .....mos. .....ds.
CONTRIBUTORY (Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) ....., M. D.
....., 19..... (Address).....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial, 19
Normal Hill,	6/20/29
20. Undertaker	Address
Brower-Mann Co.	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66602

PLACE OF DEATH
County of Jerome
City of Eden

Registration District No. 36
Primary Registration District No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10
Mrs. Davis

2. FULL NAME Mary McNee

(a) Residence. No. 1 mi west ½ mi north Eden St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of E. J. McNee

6. DATE OF BIRTH (month, day and year) Jan 12-1875

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	5	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Ernst Wadsack
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mary Yunkult
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. Earl F. Wright
(Address) Eden, Ida

15. Filed June 26, 1929 J. M. Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to June 25, 1929, that I last saw her alive on June - 21, 1929 and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH*, was as follows:
Carcinoma of Stomach
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) General Carcinoma - Toxic goiter and Nephritis
(duration) yrs. 7 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of June - 1928
Was there an autopsy? no
What test confirmed diagnosis? clinical & opsy
(Signed) J. M. Davis M. D.
June - 26, 1929 (Address) Kimberly Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	6-26 1929
20. Undertaker White Mortuary Inc	Address Twin Falls Ida

Form V. S. No. 5 20M-1-1642 RECEIVED JUL 12 1929 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66604

Registered No.

1. PLACE OF DEATH.

Registration District No. 18

County of Jerome

Primary Registration District No.

City of Jerome (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Howard Charles Dalhington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug 29 1906 (Month) (Day) (Year)

7. AGE: 22 yrs. 9 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: H. E. Dalhington

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Margrett Moore

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Dalhington

(Address) Jerome

15. Filed 6/14 1929 O. B. Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 12 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1929, to June 12 1929, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. B. Zeller M. D.

6/20 1929 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Jerome Idaho | DATE OF BURIAL: 6/14 1929

20. UNDERTAKER: D. L Henson | ADDRESS: Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & SDRS. 19760

RECEIVED JUL 12 1929

Form U. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

County of Jerome

City of Jerome

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18

Primary Registration District No.

(No. , St.)

File No. 66605

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Bond

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH: April (Month) 10 (Day) 1876 (Year)

7. AGE: 52 yrs. 11 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Jensen

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Betsey Wilburn

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dale Bond

(Address) Jerome Idaho

15.

Filed 5/25 1929 Chas F Zeller Jmc. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Deceased was found dead in bath tub due to monoxide poisoning no [illegible]

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cem

DATE OF BURIAL: May 26 1929

20. UNDERTAKER: [illegible]

ADDRESS: Jerome

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED JUL 12 1929

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

66606

1. PLACE OF DEATH.

Registration District No. 18

County of Jerome

Primary Registration District No.

File No.

City of Jerome (No. ....., ... St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cora Ada Burgoyne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: June (Month) 22 (Day) 1890 (Year)

7. AGE: 38 yrs. 10 mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montrose Colo

10. NAME OF FATHER: E. J. Price

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jim Burgoyne
(Address) Jerome Idaho

15.
Filed 5/25 1929 Chas Zeller Jr. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 1 (Day) 1929 (Year) 131

17. I HEREBY CERTIFY, That I attended deceased from May 1 1929, to May 1 1929, that I last saw h[illegible] alive on May 1 1929 and that death occurred on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Toxic Pregnancy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas F. Schmerstein M. D.

5/4/29 19 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery — DATE OF BURIAL: May 4 1929

20. UNDERTAKER: D. A. Thornton — ADDRESS: Jerome

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED JUL 12 1929

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66607

Registered No.

1. PLACE OF DEATH.

Registration District No. 14

County of Jerome

Primary Registration District No.

City of Jerome (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie Maude Zeller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Male~~ Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Single~~ Married (write word)

6. DATE OF BIRTH: Nov (Month) 12 (Day) 1878 (Year)

7. AGE: 51 yrs. 5 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: W H Mason

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Eliza Kain

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. S. Zeller
(Address)

15. Filed 6/14 1929 C. T. Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 14 (Day) 1929 (Year) 31

17. I HEREBY CERTIFY, That I attended deceased from June 5 1929, to June 14 1929
that I last saw her alive on June 14 1929
and that death occurred on the date stated above, at 9:10 P.M.

The CAUSE OF DEATH* was as follows:
Tuberculus Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. T. Zeller M. D.

19 (Address) Jerome, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cem — DATE OF BURIAL: June 17 1929

20. UNDERTAKER: D. L. Peterson — ADDRESS: Jerome

Dr Zeller

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

RECEIVED JUL 10 1929

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66608

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 37

Primary Registration District No. 2085

County of Jerome

City of Hazelton (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter A. Goellert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 22 (Day) 1887 (Year)

7. AGE: 41 yrs. 7 mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): Farm Work

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Robert Goellert

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Amalia Simonalt

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Carrie F. Goellert
(Address) Hazelton Ida.

15.
Filed 7-10 1929 H. N. Leet
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~1929~~, to ~~1929~~, that I last saw ~~him~~ alive on ~~1929~~ and that death occurred on the date stated above, at 6:35 P.M.

The CAUSE OF DEATH* was as follows:

Electrocuted, coming in contact with high voltage wire, of Idaho Power Co while tying tether.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Wiley (Coroner)

June 21 1929 (Address) Jerome, Idaho

*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls, Idaho — DATE OF BURIAL: 6-23 1929

20. UNDERTAKER: White Mortuary — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66609

PLACE OF DEATH
County of Kootenai
City of Post Falls

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 80

(No.) 142
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Darrell H. Bickett

(a) Residence. No. Post Falls, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Gertrude Bickett

6. DATE OF BIRTH (month, day and year) April 20 - 1895

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	one	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer) Rubedew Lumber Co.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Des Moines, Iowa

PARENTS

10. NAME OF FATHER Robert Bickett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not obt.
12. MAIDEN NAME OF MOTHER Verna Turner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not obt.

14. Informant Gertrude Bickett
(Address) Post Falls, Idaho

15. Filed 6/25 1929 N. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 0 m.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
in Spokane River at
Post Falls, Idaho.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) R. A. Downey Brown, M. D.
June 11, 1929 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane, Wn	June 12 1929

20. Undertaker Smith & Co Address Spokane, Wn.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66610

PLACE OF DEATH
County of Kootenai
City of

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 81

(No. 48A)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Finney

(a) Residence. No. Coeur d'Alene St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) May 28 1919

7. AGE	Years	Months	Days	If LESS than 1 day,
	10	0	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur d'Alene Idaho

PARENTS
10. NAME OF FATHER John E Finney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn
12. MAIDEN NAME OF MOTHER Harriette Lheillanty
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant John E Finney
(Address) Coeur d'Alene Idaho

15. Filed 6/26, 1929 W. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:
Endocarditis
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Flu
(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Thomas Cem	6/28 1929

20. Undertaker R B Mooney Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66611

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 82

(No.) 32
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth Irene Hansen

(a) Residence. No. 416 So 13th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 18, 1927

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur d'Alene Idaho

PARENTS

10. NAME OF FATHER Osten Hansen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Ida O Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Osten Hansen
(Address) Coeur d'Alene, Ida.

15. Filed 6/27, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10, 1929, to June 17, 1929
that I last saw her alive on June 16, 1929
and that death occurred, on the date stated above, at 7 a m.
The CAUSE OF DEATH* was as follows:
Tuberculer meningitis.
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Miliary tuberculosis.
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) John Olwell M. D.
June 17, 1929 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	6/19 1929
20. Undertaker	Address
R. B. Mooney	C'd'A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

DO NOT WRITE IN THIS SPACE

State File No. 66612

Local Registrar's No. 83

(No. 74a)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma L. Smith

(a) Residence. No. 911 Lakeside Ave St.

(Usual place of abode)

Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of A W Smith

6. DATE OF BIRTH (month, day and year) April 27, 1859

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salem Ill.

PARENTS

10. NAME OF FATHER Edward Mainey

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Mary Johnson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant A W Smith

(Address) Coeur d'Alene Idaho

15. Filed 6/27, 1929 H. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1929, to , 19

that I last saw h alive on June 6, 1929

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. O. Magee M. D.

June 8, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	6/29 1929
20. Undertaker	**Address**
R. B. Mooney	Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66613

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 84

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Olea Moe

(a) Residence. No. 703 - Government Way St.
(Usual place of abode)

48 B

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Andrew H. Moe.

6. DATE OF BIRTH (month, day and year) 1850-5-25

7. AGE Years 79 Months 0 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Hans Christofferson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway

12. MAIDEN NAME OF MOTHER Dont Know.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Andrew H. Moe
(Address) Coeur d'Alene

15. Filed 6/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to June 7, 1929

that I last saw her alive on June 7, 1929

and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

..... (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Injury to hip, by a fall

..... (duration) ..... yrs. ..... mos. 21 ds.

18. Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. J. Sturges, M. D.

June 8, 1929 (Address) By (H. T. Anderson M. D.) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Duluth, Minn. Date of Burial 6-11 1929

20. Undertaker Cassedy Funeral Home Address C D Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66614

PLACE OF DEATH
County of Kootenay
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 85

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert Mc Cluskey 1884

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Dont Know
7. AGE: Years 49 | Months | Days | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Worked in
(b) General nature of industry, business, or establishment in which employed (or employer): the woods
(c) Name of employer: Winton Lbr Co.
9. BIRTHPLACE (city or town) (State or country): X
PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)
14. Informant Dr Anderson.
(Address) Coeur d Alene.
15. Filed 6/27, 1929 W. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to June 20, 1929
that I last saw him alive on June 20, 1929
and that death occurred, on the date stated above, at 12:15 A. m.
The CAUSE OF DEATH* was as follows:
Shock, due to trauma.
Injury at Winton Camp 14, accidental, log jumped plunge.
(duration) yrs. mos. 2½ ds.
CONTRIBUTORY (Secondary) Traumatic Amputation of right leg,
(duration) yrs. mos. 2½ ds.
18. Where was disease contracted if not at place of death? /
Did an operation precede death? yes Date of June 17, 1929
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) Harold T. Anderson, M. D.
June 20, 1929 (Address) Coeur d' Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cem. C D'Alene — Date of Burial: 6-22 1929
20. Undertaker: Cassedy Funeral Hm — Address: C D'Alene

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66615

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 86

(No. 2)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hiram L. Tucker

74A

(a) Residence. No. 1302 Sixth St.
(Usual place of abode)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 5 1854

7. AGE	Years	Months	Days	If LESS than 1 day,
	74	11	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS

10. NAME OF FATHER Hiram K Tucker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Mary Jane Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant William H Tucker
(Address) St Maries Idaho

15. Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 16, 1929
that I last saw h.. alive on June 15, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY, (Secondary) Arteriosclerosis - Hypertension
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J O Dwyer, M. D.
June 17, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	6/18 1929

20. Undertaker R B Mooney Address Cd'A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66616

Local Registrar's No. 87

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 20
Primary Registration District No. 1050

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Burl T. Calkins

(a) Residence. No. N. Fourth St. 32
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1910 - 3 - 6

7. AGE	Years	Months	Days	If LESS than 1 day,
	19	3	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Worked in Mines
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) O'Neal Neb.

PARENTS

10. NAME OF FATHER Warren Calkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Maud Buell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Elsie Mich

14. Informant Martha Pettleton
(Address)

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1929, to June 11, 1929
that I last saw h[illegible] alive on June 11, 1929
and that death occurred, on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. two mos. ds.

18. Where was disease contracted if not at place of death? Do not know
Did an operation precede death? Rib resection Date of April, 1929
Was there an autopsy? no
What test confirmed diagnosis? None

(Signed) Harold T. Anderson M. D.
June 12, 1929 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CDAlene	6-13 1929
20. Undertaker	Address
Cossed Funeral Home	CDAlene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66617

PLACE OF DEATH
County of Kootenai
City of Coeur D' Alene

Registration District No. 30
Primary Registration District No. 1650
Local Registrar's No. 88

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

21

2. FULL NAME John Fletcher Eckerson

(a) Residence. No. 1033 Fourth St. Canby, Ore.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 24 1852

7. AGE Years 75 Months 5 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant J. L. Eckerson,
(Address) Coeur D' Alene, Idaho.

15. Filed 6/27, 1929. H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12, (Day) 1929 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1929, to June 12, 1929
that I last saw him alive on June 12, 1929
and that death occurred, on the date stated above, at 3:15 P. m.
The CAUSE OF DEATH* was as follows:
Erysipelas of face
(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Do not know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Harold T. Anderson M. D.
June 13, 1929 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Aurora, Oregon
Date of Burial 6/13 1929
20. Undertaker R. B. Downey Coeur d'Alene Address

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66618

PLACE OF DEATH
County of Kootenai
City of Post Falls

Registration District No. 30
Primary Registration District No. 1056

Local Registrar's No. 89

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

38 B

2. FULL NAME Marion L. Swisher

(a) Residence. No. Post Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Margeret Swisher

6. DATE OF BIRTH (month, day and year) April 24 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	1	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER William Swisher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) U. S.
12. MAIDEN NAME OF MOTHER Sarah J. Penman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) U. S.

14. Informant Mrs Margeret Swisher
(Address) Post Falls. Idaho.

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 11th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4th, 1929, to June 11, 1929
that I last saw him alive on June 8th, 1929
and that death occurred, on the date stated above, at 9 a.m.
The CAUSE OF DEATH* was as follows:

Heart Disease - Valvular

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) L. L. McCauley M. D.
June 11, 1929 (Address) Post Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Post Falls	6/14 1929
20. Undertaker	**Address**
R B Mooney	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66619

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and [illegible])

Local Registrar's No. 91

2. FULL NAME Matilda Johnson

(a) Residence. No. Route #1 — St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

46

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Frank L. Johnson

6. DATE OF BIRTH (month, day and year) 1880-4-27

7. AGE Years 49 Months 1 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10. NAME OF FATHER Jas. Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Margret Campbell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Frank L. Johnson
(Address)

15. Filed 6/27, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1929 to June 15, 1929
that I last saw her alive on June 1, 1929
and that death occurred, on the date stated above, at 7:30 a. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of uterine cervix.
..... (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of 7-1-1928
Was there an autopsy? No.
What test confirmed diagnosis? .....
(Signed) John O. Wood, M. D.
June 17, 1929 (Address) Coeur d'Alene, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene — Date of Burial 6-17 1929

20. Undertaker Cassedy Funeral Home — Address C D Alene

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66620

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 92
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Martin Briggs

(a) Residence. No. 928 7th St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 16 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	10	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mill worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Rutledge Timber Co.

9. BIRTHPLACE (city or town) (State or country) Armadias, Mich.

PARENTS

10. NAME OF FATHER John Briggs
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know.
12. MAIDEN NAME OF MOTHER Helen Stark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Violet Briggs
(Address)

15. Filed 6/27, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1928 to June 26, 1929
that I last saw him alive on June 18, 1929
and that death occurred, on the date stated above, at 7 30 a. m.
The CAUSE OF DEATH* was as follows:
Angina pectoris.

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Chronic myocardial degeneration
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Usual.
(Signed) John Allwood, M. D.
June 27, 1929 (Address) Coeur D'Alene Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CD'Alene	6-28 1929
20. Undertaker	Address
Casey Funeral Home	CD'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66621

PLACE OF DEATH
County of Kootenai
City of Coeur d Alene
Registration District No. 30
Primary Registration District No. 1050
(No. Home Hospital)
Local Registrar's No. 93
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Kutulas

(a) Residence. No. 213 Garden St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 27, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, 0 hrs. or min.
	0	0	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur d Alene Idaho

PARENTS

10. NAME OF FATHER Gust Kutulas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Greece
12. MAIDEN NAME OF MOTHER Mazie Brandish
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ogo

14. Informant Gust Kutulas
(Address) Coeur d'alene Ida.

15. Filed June 28, 1929. K. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to June 27, 1929, that I last saw him alive on June 26, 1929, and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth (6 mo)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Harold J. Sturgis, M. D.
June 28, 1929 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	June 28 1929

20. Undertaker R B Mooney Address Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66622

Local Registrar's No. 94

2. FULL NAME Adolph Molstead

44

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE W.

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Anna Marie Molstead

6. DATE OF BIRTH (month, day and year) 1858-4-29

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
71	1	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Christian Molstead

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway

12. MAIDEN NAME OF MOTHER ——

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Nils Molstead
(Address)

15. Filed 6/28, 1929. H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 26 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10, 1929 to June 26, 1929 that I last saw him alive on June 22, 1929 and that death occurred, on the date stated above, at 9:45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

..... (duration) Not known yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Xray, Physical findings

(Signed) J. C. Dwyer, M. D.

June 27, 1929 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene — Date of Burial 6-28 1929

20. Undertaker Cassedy Funeral Home — Address C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66623

PLACE OF DEATH
County of Kootenai
City of Cataldo

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 33

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dallas M Perdue

48B

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb 18, 1845

7. AGE: Years 84, Months 4, Days 2. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Minerva, Ohio

PARENTS

10. NAME OF FATHER: Benjamin R. Perdue
11. BIRTHPLACE OF FATHER (city or town) (State or Country): France
12. MAIDEN NAME OF MOTHER: Catherine Schrimer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): No information

14. Informant: Mildred Butler
(Address) Cataldo, Idaho.

15. Filed June 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from I have not seen deceased for about two years but every month or two have given advice in person to his daughter ~~with~~ who took care of him. I cannot give any particular disease except a myocarditis the result of arteriosclerosis from old age (age 84) ds.
that I last saw h..... alive on ..... 19..... and that death occurred on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none

(Signed) Geo H Kennett, M. D.
June 22, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Oskaloosa, Iowa — Date of Burial: June 24 1929

20. Undertaker: M. C. Thornhill — Address: Kellogg, Idaho

N. B.—Every item of information should be carefully supplied. Any space which cannot be given should be marked "unknown." Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66624

PLACE OF DEATH

County of Latah
City of Moscow (rural)
Registration District No. 61
Primary Registration District No. 2141
(No.)
Local Registrar's No. 30

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME FRANCIS MARION NICHOLS

(a) Residence. No. Viola ### 44

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of BELL NICHOLS

6 DATE OF BIRTH (month, day and year)

7 AGE Years	Months	Days	If LESS than 1 day, ___hrs. or ___min.
60	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER William Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Betsy Ranshere

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Otis Nichols

(Address) Viola Idaho

15 Filed June 18, 1929 W. H. Carruthers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 18 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased ~~from~~ on June 18, 1929, to ___, 19___, that I last saw h~~im~~er alive on June 18, 1929, and that death occurred, on the date stated above, at 12:00 m. noon

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach
Carcinoma Gall Bladder
(duration) ___ yrs. 6 mos. ___ ds.

CONTRIBUTORY (Secondary) Unknown
(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Harry Eichhorn M. D.

June 19 1929 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Viola Idaho	6-20 1929
20. Undertaker H. R. Short	Address Moscow Ida

RECEIVED JUL 5 1929

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 66625
Registered No.

1. PLACE OF DEATH
County of Latah
City of Troy Ida
(No. ....., ... St.)

Registration District No. 64
Primary Registration District No. 2144

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Baby) Kasper

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: June (Month) 4 (Day) 1929 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many 4 hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Troy Hospital

10. NAME OF FATHER: Adolph Kasper

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Evelyn Dalin

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adolph Kasper
(Address) Troy Ida

15.
Filed June 30 1929 Lucy M Pickard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1929, to June 4 1929, that I last saw him alive on June 4 1929, and that death occurred on the date stated above, at 8 00 M.

The CAUSE OF DEATH* was as follows:
Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas A. Meyer M. D.
June 6 1929 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Westdale cem
DATE OF BURIAL: June 5 1929

20. UNDERTAKER: John J Pickard
ADDRESS: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66626

PLACE OF DEATH
County of Idaho
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Perry Larkin
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 30 - 1841

7. AGE Years: 88 Months: 2 Days: 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: William Larkin
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maine
12. MAIDEN NAME OF MOTHER: Sicafoot
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pennsylvania

14. Informant: Ellen E Black
(Address) 133 Garfield ave Portland Ore

15. Filed June 8th, 1929 Dr. Jas. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to June 6, 1929
that I last saw him alive on June 6 1929
and that death occurred, on the date stated above, at 7:00 p m.
The CAUSE OF DEATH* was as follows:
Hemiplegia
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. D. Henry, M. D.
6 7 1929 (Address) Franklin Wash

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Garfield Wash
Date of Burial: 6 9 1929

20. Undertaker: E. H. Driver Palouse Wash.
Address

FORM V. S. [illegible] M. 1-19

RECEIVED JUL 15 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65

Primary Registration District No. 2145

File No. 66627

Registered No.

1. PLACE OF DEATH

County of Latah

City of Potlatch (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Merle Tracy (Tracy)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: Dec. (Month) 27 (Day) 1923 (Year)

7. AGE: 5 Yrs. 9 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Helmer Idaho

10. NAME OF FATHER: Harry Tracy

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Hulda Liner

13. BIRTHPLACE OF MOTHER (State or Country): Helmer

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Harry Tracy
(Address): Helmer

15. Filed July 1st 1929 D. J. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1929, to June 30th 1929, that I last saw him alive on June 30th 1929, and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:
Acute Septicemia
following injury to shoulder.
(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) ✓
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. C. Gibson M. D.
7/1/1929 (Address) Potlatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Potlatch Hospital ..... yrs. ..... mos. 5 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? ✓
Former or usual residence Helmer

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: July 2nd 1929

20. UNDERTAKER: Short — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JUL 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66628

PLACE OF DEATH
County of Latah
City of Potlatch
Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mangonuk Peterson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Not Known
7. AGE: Years: About 70; Months; Days; If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Logger.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Norway.

PARENTS
10. NAME OF FATHER: P. Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway.
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway.

14. Informant: Gunda Larson
(Address): Spokane

15. Filed July 7th, 1929. J. Jr. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 4th, 1929, to July 7th, 1929, that I last saw him alive on July 7th, 1929, and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:

Compound fracture of right femur.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Gas. gangrene
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Elk River.
Did an operation precede death? yes Date of July 5th
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) F C Severson, M. D.
July 7th, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Palouse Wash. Date of Burial: July 9 1929
20. Undertaker: E. M. Irwin Address: Palouse Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66629

PLACE OF DEATH
County of Latah
City of Pottatch

Registration District No. 65
Primary Registration District No. 2145
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

58 B

2. FULL NAME Evthimois Dimas

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 51 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Pottatch Lum. Co

9. BIRTHPLACE (city or town) (State or country): Greece

PARENTS

10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): " "
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: John Diamantis
(Address): Elk. River Ida

15. Filed June 20th, 1929 Dr. M. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June - 6th, 1929, to June 16th, 1929
that I last saw him alive on June 15th, 1929
and that death occurred, on the date stated above, at 4 A m.
The CAUSE OF DEATH* was as follows:
Chronic Valvular disease
..... (duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) F. C. Gibson, M. D.
June 16th, 1929 (Address) Pottatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Palouse Wash | Date of Burial: June 18 1929

20. Undertaker: E. H. Drum | Address: Palouse Wash

RECEIVED JUL 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66630

PLACE OF DEATH
County of Lewis
City of Craigmont.

Registration District No. 50
Primary Registration District No. 2129
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

74a

2. FULL NAME Forest Randolph Beeman

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. 9 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of ~~(or WIFE of~~ Dora Bell Beeman

6. DATE OF BIRTH (month, day and year) July 16 – 1878

7. AGE Years 50 Months 9 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Well Driller
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER Alfred Beeman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Olive Cox
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Clair W. Wamsley
(Address) Craigmont Ida

15. Filed 5/10, 1929. R E Dillebh Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2, 1929, to May 6, 1929
that I last saw him alive on May 6, 1929
and that death occurred, on the date stated above, at 1:25 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral apoplexy
..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? unused
(Signed) R E Dillebh, M. D.
5/8, 1929 (Address) Craigmont

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Craigmont, Ida. Date of Burial 5/8 1929

20. Undertaker Star Hdwe + Imp Co Address Craigmont,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66631

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 50
Primary Registration District No. 2179
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

131

2. FULL NAME Mary F. Harwood
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or ~~Divorced~~ (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Harwood
6. DATE OF BIRTH (month, day and year) Feb 1 1854
7. AGE Years 75 Months 2 Days 29 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) ~~Illinois~~ Iowa

PARENTS
10. NAME OF FATHER Silas Francis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER ~~Nancy~~ Alestia Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Theodore Harwood
(Address) Winchester Ida
15. Filed 5/10, 1929 R C Dewey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 30 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 11th, 1929, to Apr 30, 1929
that I last saw her alive on Apr 30, 1929
and that death occurred, on the date stated above, at 11 50 A.m.
The CAUSE OF DEATH* was as follows:
Uremic Coma
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrage
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. C. McLaughlin M. D.
May 1st 1929 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Golden Ridge Cemetery Winchester
Date of Burial May 2 1929
20. Undertaker Star Hdwe + Imp Co
Address Craigmont Ida

RECEIVED JUL 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66632

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 60
Primary Registration District No. 2/29
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

41

2. FULL NAME Jim Sing

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Chinaman
5. Single, Married, Widowed, or Divorced (write the word) —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6. DATE OF BIRTH (month, day and year) unknown

7. AGE 67 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Cook
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) —

PARENTS
10. NAME OF FATHER —
11. BIRTHPLACE OF FATHER (city or town) (State or Country) —
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant C. E. Clovis
(Address) Craigmont Ida

15. Filed 5/10, 1929 R. E. Dell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April - 29 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22, 1929 to April 29, 1929
that I last saw him alive on April 29, 1929
and that death occurred, on the date stated above, at 4:40 a.m.
The CAUSE OF DEATH* was as follows:
Toxemia following Absorption from Gangrenous foot
(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) John F. Gist, M. D.
4/30 1929 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Craigmont Ida | Date of Burial 4/30 1929
20. Undertaker Clyde Clovis | Address Craigmont Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JUL 15 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Lewis

City of Kamiah

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2478

Primary Registration District No. 49

(No. ..... St.)

State File No. 66633

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Carter Daty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Wid

6. DATE OF BIRTH: Aug (Month) 27 (Day) 1858 (Year)

7. AGE: 70 Yrs. 10 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF Father: Allen Carter

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Harrington

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dorothy M. Kitchen
(Address) Kamiah Idaho

15. Filed 7/2 1929 [signature] Acty Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 74a 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1929 to above 19..., that I last saw her alive on July 1st 1929, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

7/2 1929 (Address) Kamiah, Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grangeville Ida

DATE OF BURIAL: 7/3 1929

20. UNDERTAKER: J. W. Robertson

ADDRESS: Kamiah Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

very item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66634

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 60
Primary Registration District No. 2129
Local Registrar's No. 12

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Andrew Gabriel Son

(a) Residence. No. Winchester Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Gabrielson

6. DATE OF BIRTH (month, day and year)

7. AGE: 57 Years | Months 3 | Days 8 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED: Mill
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Craig Limb. Co.

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Gustav Gabrielson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Rebecca Larson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Mrs. A. Gabrielson
(Address) Winchester Idaho.

15. Filed 6/29, 1929. R. E. Duncan Registrar

Removal Winchester to Lewiston

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 24 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24, 1929 to June 24, 1929
that I last saw h— alive on June 24, 1929
and that death occurred, on the date stated above, at 6 o'clock P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemmorhage

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
Nephritis, (duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) John F. Hunt M. D.
June 25 1929 (Address) Winchester Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho — Date of Burial: June 26 1929
20. Undertaker: Brown-Wamm Co — Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM [illegible] RECEIVED JUL 5 1929

William Gerald

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66635

Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lewis

City of Craigmont Idaho

Registration District No. 60

Primary Registration District No. 2129

No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Gerald Anderson. Wm. G. Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. — (Write the word.)

6. DATE OF BIRTH. June (Month) 18 (Day) 1887 (Year)

7. AGE 42 Yrs. ..... Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Chicago Ill

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl Elash

(Address) Lewiston Ida

15. Filed 6/28 1929 R. E. Dwelle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 205-a

Mayne (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Heart Trouble

..... (Duration) ..... yrs. ..... mos. ..... ds.

6/25 1929 (Signed) Albert Huff Coroner Mr D.

(Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery Craigmont, Idaho.

DATE OF BURIAL: June 28 1929

20. UNDERTAKER: Star Hdwe & Impl Co

ADDRESS: Craigmont

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BGRS. 24653

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66636

PLACE OF DEATH

County of Madison
City of Rexburg

CERTIFICATE OF DEATH

Registration District No. 100
Primary Registration District No. 2[illegible]
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 53

2. FULL NAME Bert W. Robinson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate Robinson

6 DATE OF BIRTH (month, day and year): Sept. 12 1876

7 AGE: Years 52 | Months 9 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Circus
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: Robinson Bros. Circus

9 BIRTHPLACE (city or town) (State or country): Watterloo Iowa.

PARENTS
10 NAME OF FATHER: William Robinson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Watterloo Iowa.
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Watterloo Iowa.

14 Informant: Kate Robinson
(Address): Campton Cal.

15 Filed July 1st, 1929 J. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 30 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to June 30, 1929, that I last saw him alive on June 30, 1929, and that death occurred, on the date stated above, at 8:00 P m.

The CAUSE OF DEATH* was as follows: Acute Septicemia following Lion Bite, popliteal space left leg.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? While in Show at Driggs Ida.
Did an operation precede death? Yes Date of June 30.
Was there an autopsy? Opening H Abscess
What test confirmed diagnosis?
(Signed) H B Rigby, M. D.
July 1, 1929 (Address) Rexburg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rexburg Cemetery
Date of Burial: 7/1 1929

20. Undertaker: A B Eckersell
Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT R[illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated [illegible]TLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Ex[illegible]ement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66637

PLACE OF DEATH
County of Madison
City of Salem

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. V2

44

2. FULL NAME Laura Eliza Loveland.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Married.

5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of Eldorus Pertum Loveland.

6. DATE OF BIRTH (month, day and year) May 7. -1877.

7. AGE Years 52 Months 1 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) at Home.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Albion Idaho.

PARENTS

10. NAME OF FATHER Charles Monroe Gray.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Clay County. Mo.
12. MAIDEN NAME OF MOTHER Sarah Elizabeth Stephenson.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant E. B. Loveland.
(Address) Rexburg. R. F. D. #2

15. Filed 7/2, 1929 J Ryoung Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1929, to June 8, 1929
that I last saw his alive on June 8, 1929
and that death occurred, on the date stated above, at 10:a m.
The CAUSE OF DEATH* was as follows:
Carcinoma Rt.
with mestatasis to abdomen
liver & lungs.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes. Date of April.
Was there an autopsy? no.
What test confirmed diagnosis? Pathologic Examination
(Signed) H B Rigby, M. D.
July 2, 1929 (Address) Rexburg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sugar City. Ida. Date of Burial July 3rd 1929.
20. Undertaker Vern J. Keller. Address Rexburg

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66638

PLACE OF DEATH

County of Madison
City of Burton

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 51

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thelma Beck Kauer

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 4th -1927

7. AGE	Years	Months	Days	If LESS than 1 day,
	2		24	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burton Madison County

PARENTS

10. NAME OF FATHER Fred Kauer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Rosa Beck

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Fred Kauer
(Address) Burton Idaho

15. Filed 6/29, 1929 J. Rymer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28, 1929, to June 28, 1929
that I last saw her alive on June 28, 1929
and that death occurred, on the date stated above, at 6:45 A. m.
The CAUSE OF DEATH* was as follows: Acute Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) M. Kurtzgaard, M. D.
6-28, 1929 (Address) Pierburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Burton cemetery	
20. Undertaker Chris Keller	Address Pierburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66639

PLACE OF DEATH

County of Madison
City of Rexburg

CERTIFICATE OF DEATH

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 50

2. FULL NAME John Edwards

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

206

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Stillborn

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stillborn

6 DATE OF BIRTH (month, day and year)

7 AGE: Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stillborn
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rexburg Idaho.

PARENTS
10 NAME OF FATHER: Earl R. Edwards
11 BIRTHPLACE OF FATHER (city or town) (State or country): Carey Idaho
12 MAIDEN NAME OF MOTHER: Mable Dailey
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Marysville Idaho.

14 Informant: Earl Edwards
(Address): Rexburg Idaho

15 Filed 6/29, 1929 J Ryan Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 6 (Month) 28 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Still birth

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) M Duthuland, M. D.
6-28, 1929 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rexburg Cemetery
Date of Burial: 6/29 1929

20. Undertaker: A B Eckersell
Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

173375 +

Form V. S. No. 5 ~~20M-1-16-12~~

RECEIVED JUL 11 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66641

Registered No. 48

1. PLACE OF DEATH.

County of Madison

City of Thornton (No. ....., ... St.)

Registration District No. 100

Primary Registration District No. 2178

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tomio Shigihara

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: April 25 (Month) 1929 (Year)

7. AGE: ..... yrs. 1 mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Thornton

10. NAME OF FATHER: Sannoshike Shigihara

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed 6/15 1929 W Lyons Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 14 (Day) 1929 (Year) 101 B

17. I HEREBY CERTIFY, That I attended deceased from June 13 1929, to June 14 1929 that I last saw him alive on June 14 1929 and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Empyema Rt lung +

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N B Rigby M. D.

June 14 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg Cemetery | DATE OF BURIAL: 6/15 1929

20. UNDERTAKER: A B Eckersell | ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

APPLICATION HAVING BEEN MADE for the disinterment of the body of Tomio Shigahari

now lying buried in Rexburg Cemetery, in the City or Town of Rexburg

County of Madison State of Idaho, who died on the 14 day of June, 1929, Aged ____ years 1 months

21 days, the cause of death being Pneumonia and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

H. B. Rigby, M.D. attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private
private or railway conveyance

to Pleasant View City Cemetery in the City or Town of Burley County of Cassia

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Madison it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 2nd day of February, A.D. 19 70.

Permit issued to:
Robert C. Walk
710 - 6th St.
Rupert, Idaho 83350

W. W. Benson
by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of _____ State of Idaho, this _____ day of _____, 19__.

_____
Health Officer

FORM BH 56-019

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66642

PLACE OF DEATH

County of Madison
City of Sugar

Registration District No. 100
Primary Registration District No. 278
Local Registrar's No. 47

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME James Ervin Weaver

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June-12-1929

7. AGE Years | Months | Days: I | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sugar City

PARENTS

10. NAME OF FATHER Austin Leroy Weaver

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Florance Kid

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kantucky

14. Informant Austin L Weaver
(Address) Sugar City

15. Filed 6/14, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1929, to June 12, 1929
that I last saw him alive on June 12, 1929
and that death occurred, on the date stated above, at 11:45P m.
The CAUSE OF DEATH* was as follows: Atelectics Rt. Lung.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. B. Rigby, M. D.
June 14, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sugar City Cemetary | Date of Burial: 19

20. Undertaker: Alvin Keller | Address: Beneficial Mortuary. Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66643

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. 13th. St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas. Bernard Wade 74a

(a) Residence. No. 13th. St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 8, 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	67	9	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dentist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) La Pierre, Mich.

PARENTS

10. NAME OF FATHER L. N. Wade
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Julia Bainard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y.

14. Informant Amanda C. Wade
(Address) Lewiston, Ida.

15. Filed June 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May, 28th. 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1929, to May 28th, 1929
that I last saw h. alive on May 28th, 1929
and that death occurred, on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:

Apoplexy 2nd attack.
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteri-sclerosis. (H.B.P.)
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Confirmed by
(Signed) E. L. White. M. D.
5-29, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Normal Hill, Lewiston, Ida.	5/30
20. Undertaker	**Address**
Brower-Wann Co., Lewiston,	Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66644

PLACE OF DEATH

County of Nezperce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace L. Cook

(a) Residence. No. 308 Prospect Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of E.S Cook

6. DATE OF BIRTH (month, day and year) May 11 1866

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63		16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Peoria, Ill

PARENTS

10. NAME OF FATHER Emery Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fine, New York
12. MAIDEN NAME OF MOTHER Sharlet Chellis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Manchester, Vermont.

14. Informant E.S. Cook
(Address) Lewiston, Idaho.

15. Filed June 6, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to May 27, 1929
that I last saw h alive on May 27, 1929
and that death occurred, on the date stated above, at 11 30 A m.
The CAUSE OF DEATH* was as follows:

Carcinoma - Pelvis -

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M. D.
5-27, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Springfield, Mass.	5/28 1929

20. Undertaker H.R. Merchant Address Clarkston Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66645

PLACE OF DEATH
County of Nez perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. Drowning, Clearwater River)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

142

2. FULL NAME Benjamen Eppa Wilson

(a) Residence. No. Rubens St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 18, 1854

7. AGE	Years	Months	Days	If LESS than 1 day,
	74	10	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS

10. NAME OF FATHER David Wilson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) W. Va.
12. MAIDEN NAME OF MOTHER Amanda Carter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Va.

14. Informant Mrs. L. M. Carter
(Address)

15. Filed June 8, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Accidental Drowning
Hung on to a log until he
drowned, (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E M Brown, M. D.
5/28, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rubens Idaho	5/29 1929
20. Undertaker	**Address**
Brown-Mann Co	Lewiston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66646

PLACE OF DEATH
County of Nez Perce
City of Idaho

Registration District No. 96
Primary Registration District No. 1009

Local Registrar's No. Inman

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Shelton

(a) Residence. No. 1218 Snake River Ave. St. 90
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) February 9 1853

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	76	3	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Elijah Shelton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Elenor Blagg
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Geo. Shelton
(Address) Lewiston Idaho

15. Filed June 8, 1929 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1929, to ____, 19____
that I last saw h____ alive on May 21, 1929
and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:
Heart failure after Dayelisida Stroke

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) LaFayette Inman, M. D.
5/28, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	19
20. Undertaker	Address
Brown-Ware Co	Lewiston Ida

Dr Lyle

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66647

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Berry S. McCracken

119

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 23 - 1850

7. AGE: Years 79 | Months — | Days — | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Not Known

PARENTS
10. NAME OF FATHER: McCracken
11. BIRTHPLACE OF FATHER (city or town) (State or Country): not Known
12. MAIDEN NAME OF MOTHER: Lelly May Hutchins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Addie Edwards
(Address) Lewiston

15. Filed June 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar, 1929, to May 23 1929
that I last saw him alive on May 23 1929
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:
Chronic Cystitis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J N Lyle M. D.
5-27 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston | Date of Burial: 5/25 1929

20. Undertaker: Vassars | Address: Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66648

PLACE OF DEATH

County of Nezperce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. 1221 - 12th. Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME Gordon Lee Martin

(a) Residence. No. 1221 - 12th. Ave. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
---	---	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston

PARENTS

10. NAME OF FATHER C. H. Martin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER May Lee
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant C. H. Martin
(Address) Lewiston, Ida.

15. Filed June 8, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May , 20 , 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 29 1929
that I last saw h[illegible] alive on May 25, 1927
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows: Infantile debility.
No strength when born.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) No evidence of disease
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. M. Gale M. D.
5-24 1927 (Address) Lewiston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Normal Hill, Lewiston	5/21/29

20. Undertaker Brower-Mann Co. Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

White

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66649

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No.) (B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Nina Augusta Utter

(a) Residence. No. 331 - 1st Ave St. Coeur D'Alene Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of R. A. Utter

6. DATE OF BIRTH (month, day and year) June 11 - 1890

7. AGE	Years	Months	Days	If LESS than 1 day,
	38	11	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington

PARENTS

10. NAME OF FATHER C. A. Parrott
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Alice Fisher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant E. Parrott
(Address) Spokane, Wash.

15. Filed June 8, 1929 Erman E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17, 1929, to May 18, 1929
that I last saw her alive on May 18, 1929
and that death occurred, on the date stated above, at 3 20 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary T. B.
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Same
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Confirmed Symptoms
(Signed) E. L. Whitt, M. D.
5-27, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	5/20 1929
20. Undertaker	Address
Dasaars	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66650

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. White's Hospital) 4613
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Rebecca Shirley Johnson

(a) Residence. No. St. Kamiah Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Indian	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 8 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	2	8	—

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kamiah Idaho

PARENTS

10. NAME OF FATHER Frank E. Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pendleton Ore.
12. MAIDEN NAME OF MOTHER Ella McFarland.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kamiah Idaho

14. Informant Frank E Johnson
(Address) Kamiah Idaho

15. Filed June 8, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to May 16, 1929
that I last saw her alive on May 16, 1929
and that death occurred, on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:

Myocarditis
Acute dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M. D.
5-17, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial~~ Cremation, or Removal	Date of Burial
Kamiah Idaho	5/17 1929

20. Undertaker Vassar Mortuary Address Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66651

Registration District No. 95
Primary Registration District No. 1009
Local Registrar's No.

164

PLACE OF DEATH

County of Nez Perce
City of Culdesac.
(No. Culdesac.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jas. H. Green

(a) Residence. No. Culdesac. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 26, 1847

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	81	7	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10. NAME OF FATHER Israel Green
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant F. M. Rogers
(Address) Culdesac.

15. Filed June 6, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:

Senility

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
(Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) F. M. Rogers Coroner
May 16, 1929 (Address) Lewiston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Normal Hill Cemetery	May 16. 1929
20. Undertaker	Address
Brown-Wann	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

JUL 5 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66652

PLACE OF DEATH

County of Nezperce

City of Lesiston

Registration District No. 96

Primary Registration District No.

Local Registrar's No.

(No. Whites Hospital 1009)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Daniel Nathan Wright

90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Cecelia Herrick

6. DATE OF BIRTH (month, day and year): August 1859

7. AGE: Years 79 | Months 9 | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Chas. O Wright
(Address): Clarkston, Wash.

15. Filed June 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. McElvain, M. D.

5-14, 1929 (Address) Wash

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clarkston, Wash | Date of Burial: 19

20. Undertaker: N. R. Merchant | Address: Clarkston Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66653

PLACE OF DEATH

County of Nezperce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Minnie Myrtle Mc.Cune

(a) Residence. No. Joseph, Idaho St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6. DATE OF BIRTH (month, day and year) July 3, 1881

7. AGE	Years	Months	Days	If LESS than 1 day,
	47	10	9	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mother

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montgomery Co. Kans.

PARENTS

10. NAME OF FATHER Wm. Bloucet

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Anna Wise

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Adaline Keener
(Address) Culdesac, Ida.

15. Filed June 8, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May, 12th. 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3rd, 1929, to May 12, 1929
that I last saw her alive on May 12, 1929
and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Heart disease- Myocarditis
(acute dilitation.) 2 2 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of sig moid.
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of May 11th 29
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. Whitt, M. D.
5-16, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
NormalHill, Lewiston, Idaho	5/13/2 19

20. Undertaker	Address
Brower - Wann Co.	Lewiston, Ida.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66654

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

179

2. FULL NAME Archibald Poole

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 20th 1905

7. AGE	Years	Months	Days	If LESS than 1 day,
	23	5	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farm Hand.
(b) General nature of industry, business, or establishment in which employed (or employer) Farm Labor.
(c) Name of employer L. F. Anderson

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER John Poole
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Netherlands
12. MAIDEN NAME OF MOTHER Inga Knapp.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant C. F. Poole
(Address) Weippe Idaho

15. Filed June 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8, 1929 to May 8, 1929
that I last saw him alive on May 8, 1929
and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Burns - over entire body
Accidental - gasoline explosion -
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Signs.

(Signed) Wm. [illegible] M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	5/10 1929

20. Undertaker Vassar Mortuary Lewiston Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Dr Brad[illegible] RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66655

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1099
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Elyna Daugherty
(a) Residence. No. [illegible] Reubens Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

111a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of AC Daugherty
6. DATE OF BIRTH (month, day and year) Sept 3d 1859
7. AGE Years 69 Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Kansas.

PARENTS
10. NAME OF FATHER Louis Russell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.
12. MAIDEN NAME OF MOTHER Mary Perkins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) [illegible] Mo

14. Informant AC Daugherty
(Address) Reubens Idah
15. Filed June 8 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 6 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 7:30 P.M. May 6 1929, to 10:30 P.M. May 6 1929
that I last saw her alive on May 6 10 P.M. 1929
and that death occurred, on the date stated above, at 10:45 A.m.
The CAUSE OF DEATH* was as follows:
Perforated gastric ulcer, general peritonitis
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Reubens Idaho
Did an operation precede death? Yes Date of May 6
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) R. T. Scott, M. D.
May 7, 1929 (Address) Lewiston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Reubens Idaho — Date of Burial 19
20. Undertaker: Vassars — Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12 RECEIVED JUL 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

(No. 540 Park St.)

File No. 66656

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Catharyn Lathrum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH: January (Month) 28 (Day) 1833 (Year)

7. AGE: 96 yrs. 3 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bedford, Pennsylvania

10. NAME OF FATHER: Samuel Horton

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: — Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S M Lathrum

(Address) Oakesdale, Wash.

15.

Filed June 8 1929 Susan E Brun
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1927, to ..... 191..., that I last saw her alive on ..... 191..., and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Cardio Nephritis cum arterial Sclerosis

(Duration) 10 yrs. ..... mos. ..... ds.

Contributory (Secondary) Not known

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John N. Alley M. D.

May 5 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakesdale, Washington

DATE OF BURIAL: May 7 1929

20. UNDERTAKER: L. L. Bruning

ADDRESS: Colfax, Wash.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66657

PLACE OF DEATH

County of Nez Perce.
City of Jammany

Registration District No. 95
Primary Registration District No. 1009
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

179

2. FULL NAME Albert Jackson Hull.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 5/24/1861.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67.	11.	10.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boon county, Iowa.

PARENTS

10. NAME OF FATHER Nathan R. Hull.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Matilda Long.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky.

14. Informant Curtis Hull.
(Address) Lewiston, Idaho.

15. Filed June 8, 1929 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 4th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1929, to May 4 1929, that I last saw h[illegible] alive on May 4 1929, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinic tests

(Signed) O. O. Tearadow, M. D.
5/6/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	5/6/29. 19

20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66658

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.

PLACE OF DEATH

County of Nez Perce
City of Lewiston
St. Joseph Hospital (No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Augusta M Anderson

(a) Residence. No. Clarkston Wash St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John N Anderson

6. DATE OF BIRTH (month, day and year) Jan 29 1874

7. AGE	Years	Months	Days	If LESS than 1 day,
	57	3	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Louis Matson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant John N Anderson
(Address) Clarkston Wash

15. Filed June 5, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 3, 1929
that I last saw her alive on May 3, 1929
and that death occurred, on the date stated above, at 3 15 0 m.
The CAUSE OF DEATH* was as follows: Uremia

(duration) — yrs. — mos. 3 ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
Unknown (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At Place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) A Bloomquist, M. D.
5/4, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Masonic Idaho	5/5 1929
20. Undertaker	Address
H P Merchant	Clarkston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Carsow RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66659

PLACE OF DEATH
County of Ney Perce
City of Near Lewiston

Registration District No. 95
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Ida May Rowley

90

(a) Residence. No. Lower Tamarack Near Lewiston St. Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Maried

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Rowley

6. DATE OF BIRTH (month, day and year) May 1 - 1866

7. AGE Years 63 Months 1 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER Norman Wood.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) —
12. MAIDEN NAME OF MOTHER Cynthia Sulivan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Mrs W W Carpenter
(Address) Lewiston Ida

15. Filed July 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 23d (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1st, 1929, to June 23rd, 1929
that I last saw her alive on June 23rd, 1929
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chr Parenchymatous Nephritis
(duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of 6/26
Was there an autopsy? no
What test confirmed diagnosis? urine and Heart Examination
(Signed) O C Carsow, M. D.
6/26, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho — Date of Burial 6/26 1929

20. Undertaker Jassar Mortuary — Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Kootenai
City of Lapwai R.R.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009
(No. ..... St.)

State File No. 66660
Local Registrar's No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James H. Lassmill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: March 3 1856 (Month) (Day) (Year)

7. AGE: 73 Yrs. 3 Mos. 20 ds. | IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: (Retired farmer)
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Walla Walla Wn

10. NAME OF Father: Isaac L. Lassmill

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Floyd Lassmill
(Address): Lapwai Idaho

15. Filed July 1 1929 Susan E. [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 23 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from did not see them alive, 19..., that I last saw h..... alive on ....., 19..., and that death occurred on the date stated above, at 5:50 P.M.

The CAUSE OF DEATH* was as follows:
Sudden death Probable heart disease (Myocarditis)
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. O. Heck M. D.
6/24 1929 (Address) Lapwai Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho | DATE OF BURIAL: 6/27 1929

UNDERTAKER: Brown-Wann Co | ADDRESS: Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66661

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital) 88a
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Henry Frank Brooks.
(a) Residence. No. Clarkston Wash St. Clarkston Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary D. Brooks.

6. DATE OF BIRTH (month, day and year) Aug 18 1863

7. AGE Years 65 Months 10 Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS
10. NAME OF FATHER Henry Brooks.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant Garland Brooks
(Address) Spokane Wash.

15. Filed July 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2, 1929 to June 18, 1929
that I last saw him alive on June 18, 1929
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Septic Endocarditis
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Influenza Pneumonia
Empyema (duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) B Blackstone, M. D.
6/19, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial June 20 1929

20. Undertaker Vassar Mortuary
Address Lewiston Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66662

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. St. Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel O Bly.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of: Eva Bly.

6. DATE OF BIRTH (month, day and year): Nov 19th 1886

7. AGE: Years 43 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stockman
(b) General nature of industry, business, or establishment in which employed (or employer): Raising stock
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Oregon

PARENTS

10. NAME OF FATHER: Joseph Bly.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Alma Whitmore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa.

14. Informant: J.S. Bly
(Address): Rogersburg Wash

15. Filed July 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1929, to June 14 1929
that I last saw h alive on June 14 1929
and that death occurred, on the date stated above, at 4-30 P m.
The CAUSE OF DEATH* was as follows: Cancer of liver

(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 1929
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J. M. Lyle M. D.
6-15, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston — Date of Burial: 6/16 1929

20. Undertaker: Vassar Mortuary — Address: Lewiston

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66663

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1019
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME M. B. Richey

(a) Residence. No. 744 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unk

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Means Seed Co

9. BIRTHPLACE (city or town) Ohio
(State or country)

PARENTS

10. NAME OF FATHER Sam Richey
11. BIRTHPLACE OF FATHER (city or town) Va
(State or Country)
12. MAIDEN NAME OF MOTHER ?
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant M. B. Richey
(Address) Lewiston

15. Filed July 1, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1929, to June 16, 1929
that I last saw him alive on June 16, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Apoplexy
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. M. Lee M. D.
6-24, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	6/21 1929
20. Undertaker	Address
Moor-Wann Co	Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66665

PLACE OF DEATH
County of Nezperce
City of Lewiston
Registration District No. 16
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Albert Konen
(a) Residence. No. Clarkston Wash St. Clarkston Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 12 1905

7. AGE	Years	Months	Days	If LESS than 1 day,
	24	3	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer) Truck driver
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Genesee Idaho

PARENTS
10. NAME OF FATHER Peter J Konen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Anna Arnold
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Jake Konen
(Address) Lewiston Idaho.

15. Filed July 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8, 1929, to June 8, 1929
that I last saw h~~is~~ alive on June 8, 1929
and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:
Hemorrhage from R femoral artery (accidental)
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Fracture comp R High R arm (duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Asotin Co Wash
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) E E Broadrock M. D.
June 10, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19 *
Asotin Wash	
20. Undertaker	Address
Vesper Mortuary	Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Braddock.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66666

PLACE OF DEATH

County of Nezperce

City of Lewiston, Idaho

Registration District No. 95

Primary Registration District No. 1009

Local Registrar's No.

(No. 1702 - Main St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Wilhelmina Speck

(a) Residence. No. 1702 - Main St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 16, 1859

7. AGE: Years 70, Months 4, Days 19. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mobile, Ala.

PARENTS

10. NAME OF FATHER: Lewis Raue

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: ------- ---

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): France

14. Informant: Fred Kling
(Address) Lewiston, Ida.

15. Filed July 1, 1929 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June, 5, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to June 5, 1929 that I last saw her alive on June 4, 1929 and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) E G Braddock, M. D.

June 6, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Normal Hill, Lewiston, Ida. Date of Burial: 6/7/29. 19

20. Undertaker: Brower - Wann Co., Lewiston, Ida. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66667

PLACE OF DEATH
County of Ag Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 48

2. FULL NAME Charles Thomas Bennett
(a) Residence. No. Deary Idaho St. Deary Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Bennett
6. DATE OF BIRTH (month, day and year) Mar 12 1878
7. AGE Years 51 Months 2 Days 22 If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Texas
PARENTS
10. NAME OF FATHER Thomas Bennett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Melinda Vaught
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa
14. Informant Mrs Amelia Bennett
(Address) Deary Idaho
15. Filed July 1, 1929 Susan E Brune Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 4 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to June 4, 1929
that I last saw him alive on June, 1929
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:
Epithelioma of Ethmoids
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of May 1 1929
Was there an autopsy? no
What test confirmed diagnosis? microscope
(Signed) J H Crampton, M. D.
June 4, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Carkston Wash. Date of Burial 6/5 1929
20. Undertaker Vassar Mortuary Address Lewiston Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66668

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1019
Local Registrar's No.
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jennie May Elkins

(a) Residence. No. Lewiston Orchards St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 5 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Stillborn			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho.

PARENTS

10. NAME OF FATHER O E Elkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Va.
12. MAIDEN NAME OF MOTHER Jennie May Reed
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wyo.

14. Informant O E Elkins
(Address) Lewiston Orchards.

15. Filed July 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Stillborn
Placenta Previa Presentation
Labor Very Difficult
(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. M. Lee M. D.
6-6, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho. Date of Burial: 6/5 1929

20. Undertaker: Vassar Mortuary Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66669

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 749)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Linda Gillette

(a) Residence. No. (Usual place of abode) St. Nez Perce County
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Leslie Gillette

6. DATE OF BIRTH (month, day and year) 2/4/1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	3	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10. NAME OF FATHER Jonathan Frawton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y.

14. Informant Leslie Gillette
(Address) Lewiston Idaho

15. Filed July 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 3rd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31, 1929, to June 3, 1929
that I last saw h alive on June 2, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Bronchs. Pneumonia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. D. Clark M. D.
6/5, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	June 6 1929
20. Undertaker	Address
Brown-Dunn Co	Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66670

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 95
Primary Registration District No. 1009
(No. Lewiston Orchards)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

162

2. FULL NAME Arley Gene King
(a) Residence. No. Lewiston Orchards St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Infant
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) April 24 1929
7. AGE Years — Months 1 Days 10 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS
10. NAME OF FATHER Ernest King
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Josephine Wallace
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) S. Dakota

14. Informant F. R. Wallace
(Address) Lewiston Orchards

15. Filed July 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 3 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 6/3-29, 19, to 6/3-29, 19
that I last saw him alive on 6/3-29, 19
and that death occurred, on the date stated above, at 3:15 A.m.
The CAUSE OF DEATH* was as follows:
Status Lymphaticus
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) E. S. White, M. D.
, 19 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 6/4 1929
20. Undertaker Vassar Mortuary
Address Lewiston Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66671

PLACE OF DEATH
County of Nez Perce
City of Lenore

Registration District No. 93
Primary Registration District No. 2371
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

202-P

2. FULL NAME Madge Hollingsworth

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar F. Hollingsworth

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Alfred Hollingsworth
(Address) Lenore

15. Filed 3/6, 1929 Dan Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-24, 1929, to Feb 23rd, 1929
that I last saw h e alive on Feb 23rd, 1929
and that death occurred, on the date stated above, at about 2 4 m.
The CAUSE OF DEATH* was as follows:
Don't Know, but probably
a heart lesion
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Haemorrhage
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. R. Fortson, M. D.
3-5, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker W. D. Pinson	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66672

PLACE OF DEATH
County of Nez Perce
City of Lenore, P.O.

Registration District No. 93
Primary Registration District No. 2371
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lee Mathews
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bernice McFadden

6. DATE OF BIRTH (month, day and year) 1871 - 2 - 16

7. AGE: Years 58, Months 4, Days 8. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Harrison Co. West Va.

PARENTS
10. NAME OF FATHER: Benjamine Mathews
11. BIRTHPLACE OF FATHER (city or town) (State or Country): West Virginia
12. MAIDEN NAME OF MOTHER: Melvina Thompson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): West Virginia

14. Informant
(Address)

15. Filed 6/25, 1929 Dan Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19, to ✓, 19
that I last saw h ✓ alive on ✓, 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Accident (?) Gunshot wound behind R X Ear
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) ✓ ✓
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? ✓ Date of ✓
Was there an autopsy? See Coroners Report
What test confirmed diagnosis?
(Signed) J. F. Robertson, M. D.
6/25, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sunyside Cemetary
Date of Burial: June 26 1929
20. Undertaker
Address

Brower.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66673

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Nez Perce.

City of Peck.

Registration District No. 93

Primary Registration District No. 2371

Local Registrar's No.

(No. 74A)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lawson W. Warlick.

(a) Residence. No. St. Peck, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 5/5/1860.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68.	10.	13.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Alabama.

PARENTS

10. NAME OF FATHER Lawson Warlick.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.

12. MAIDEN NAME OF MOTHER ------- McGinnis.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant P. W. Brower

(Address) Lewiston, Idaho.

15. Filed 3/20, 1929 Dan Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 18th, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. W. Brower Coroner

3/19/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	3/20/29. 19

20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 RECEIVED JUL 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida

City of Malad

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26

Primary Registration District No. 2069

(No. ..... St.)

File No. 66674

Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eleanor Wagon (Indian Child)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: June (Month) 17 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Washikie Ut.

10. NAME OF FATHER: John Wagon

11. BIRTHPLACE OF FATHER (State or Country): Wyo.

12. MAIDEN NAME OF MOTHER: Teenie Jacks

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Woonsook

(Address) Washikie Ut.

15. Filed 6/30 1929 J. M. Kerns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1929 (Year) 100a

17. I HEREBY CERTIFY, That I attended deceased from June 22 1929 to June 23 1929 that I last saw her alive on June 23 1929 and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia ?

..... (Duration) ..... Yrs. ..... mos. ? ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

6/23 1929 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Washikie Ut. DATE OF BURIAL: June 26 1929

20. UNDERTAKER: J. Guy Benson ADDRESS: Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. RECEIVED JUL 5 1929

CERTIFICATE OF DEATH

Registration District No. 26

Primary Registration District No. 2069

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66675

Registered No. 14

1. PLACE OF DEATH

County of Oneida

City of Tamania

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Davis John

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Feb. (Month) 20 (Day) 1922 (Year)

7. AGE: 7 Yrs. 2 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tamania Ida

10. NAME OF FATHER: Henry E. John

11. BIRTHPLACE OF FATHER (State or Country): Tamania Ida

12. MAIDEN NAME OF MOTHER: Eliza Davis

13. BIRTHPLACE OF MOTHER (State or Country): Tamania Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry E. John
(Address) Tamania Ida

15. Filed 6/30 1929 J. M. Nerus
Local Registrar

MEDICAL CERTIFICATE OF DEATH

41

16. DATE OF DEATH: June (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1929 to June 18 1929 that I last saw him alive on June 18 1929 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Septic sore throat

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) Bad tonsils

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Mabey M. D.

6/18 1929 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Tamania Ida | DATE OF BURIAL: June 20 1929

20. UNDERTAKER: J. Guy Benson | ADDRESS: Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 66676
Registered No. 13

1. PLACE OF DEATH
County of Oneida
City of Malad (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Boling Cooke.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: May (Month) 7 (Day) 1855 (Year)

7. AGE: 74 Yrs. 1 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Plesantgrove Utah.

10. NAME OF FATHER: John W. Lusk.

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Matilda Park.

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary B Hughes
(Address) .....

15. Filed 6/30 1929 J. M. Harris
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1928 to June 9 1929
that I last saw h.e alive on June 7 1929
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Chronic Glomerulitis
nephritis, Uraemia
Mitral stenosis etc.
(Duration) ? Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. F. Mabey, M. D.
6/8/1929 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Ida. DATE OF BURIAL: June 12 1929

20. UNDERTAKER: J. Guy Benson ADDRESS: Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M—1-19

RECEIVED JUL 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 26

Primary Registration District No. 7069

File No. 66677

County of Oneida

City of Black Pine Ida (No. ....., ... St.)

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donetta Fay Mills

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April (Month) 14 (Day) 1923 (Year)

7. AGE: 6 Yrs. 1 Mos. 26 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Snowville Utah

10. NAME OF FATHER: Thomas Mills

11. BIRTHPLACE OF FATHER (State or Country): New Zeland.

12. MAIDEN NAME OF MOTHER: Inga Emmerson

13. BIRTHPLACE OF MOTHER (State or Country): Huntsville Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos Mills

(Address) Black Pine Ida

15. Filed 6/30 1929 J. M. Kerns Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1929 to June 9 1929 that I last saw h. alive on June 9 1929 and that death occurred on the date stated above, at 10:45 P.M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

Mitral Insufficency

(Duration) 10 Yrs. 7 mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. 0 mos. 13 ds.

(Signed) C. W. Wadleigh M. D.

June 10 1929 (Address) Snowville Utah

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: June 12 1929

20. UNDERTAKER: Lundquist — ADDRESS: Ogden Utah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED JAN 22 1930 JUL 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida

City of Malad R.F.D. 2

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26

Primary Registration District No. 2064

No. ..... St.)

File No. 66678

Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth Vondella Howell Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 17 (Day) 1907 (Year)

7. AGE: 21 Yrs. 6 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Woodruff Idaho.

10. NAME OF FATHER: John C. Howell

11. BIRTHPLACE OF FATHER (State or Country): Portage Utah

12. MAIDEN NAME OF MOTHER: Margaret R. John

13. BIRTHPLACE OF MOTHER (State or Country): Portage Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Smith

(Address) Malad R.F.D. # 2

15. Filed June 30 1929 J. McKerns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1929 (Year) 92

17. I HEREBY CERTIFY, That I attended deceased from ~~Jan~~ May 18 1929, to June 3 1929 that I last saw her alive on May 30 1929, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Embolism

(Duration) ..... Yrs. ..... mos. Stat ds.

Contributory (Secondary) ~~Labor~~ May 18 1929

Labor (Duration) Confinement yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

6/5 1929 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Portage Utah

DATE OF BURIAL: June 6 1929

20. UNDERTAKER: J. Guy [illegible]

ADDRESS: Malad

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. [illegible] RECEIVED JUL 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 74
Primary Registration District No. 2151
File No. 66679
Registered No. 47

1. PLACE OF DEATH

County of Owyhee
City of Bruneau
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harriet Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Married.

6. DATE OF BIRTH: April (Month) 16 (Day) 1860 (Year)

7. AGE: 69 Yrs. 2 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Rogers.

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Ann Lucas

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Susan Tate.
(Address) Bruneau.

15. Filed July 3rd 1929 W. J. Edwards Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1925 to June 4 1929
that I last saw her alive on June 4 1929
and that death occurred on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) 6 yrs. ..... mos. ..... ds.

(Signed) J. Edwards M. D.
6-6-1929 (Address) Mt. Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bruneau	June 6 1929
20. UNDERTAKER C. G. Zacher	ADDRESS Mt. Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 2 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Owyhee

City of King Hill

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 74

Primary Registration District No. 2151

(No. ..... St.)

State File No. 66680

Local Registrar's No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hank Olson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	single

6. DATE OF BIRTH

Not known 1
(Month) (Day) (Year)

7. AGE

About 77 years
Yrs. Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Trapper

(b) General nature of industry, business or establishment in which employed (or employer) ~

9. BIRTHPLACE (State or Country) Holland

10. NAME OF Father Not known

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. F. Murphy

(Address) King Hill

15. Filed July 1st 1929 W J Eckenbeck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 749

June 15th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to ..... 19 ....., that I last saw h..... alive on ..... 19 ....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy

County charge found dead by neighbors

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W J Eckenbeck Co. Coroner M. D.

6/16 1929 (Address) Grand View

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt. Home	6/17 1929
20. UNDERTAKER C. G. Zacker	ADDRESS Mt Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66681

PLACE OF DEATH
County of Owyhee
City of Homedale

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 57
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

46

2. FULL NAME Alice Leola Splawn

(a) Residence. No. Homedale - Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE Wh.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Splawn

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
37	2	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Floyd Burke
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Clifford Winston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Frank Splawn
(Address) Homedale - Idaho

15. Filed 6-26-, 1929- John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11th, 1929, to June 24th 1929
that I last saw her alive on June 26th, 1929
and that death occurred, on the date stated above, at 10.30 P. m.
The CAUSE OF DEATH* was as follows:
Metastatic carcinoma of mediastinum and right Kidney region.
..... (duration) 0 yrs. 3 mos. 0 ds.
CONTRIBUTORY (Secondary) Amputation of breast for carcinoma (duration) 1 yrs. 4 mos. 0 ds.

18. Where was disease contracted if not at place of death? Sanders, Wyo.
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? X-ray diagnosis
(Signed) Geo. D. A. Kellogg, M. D.
6/25/, 1929. (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Nampa Idaho Cem. Date of Burial 6-28- 1929.

20. Undertaker Paul L Case Address Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

PLACE OF DEATH

County of Owyhee

City of ~~Homedale~~ Marsing

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66682

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 58

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME James Oscar Swinney

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Della Swinney

6. DATE OF BIRTH (month, day and year) May 14, 1886

7. AGE: Years 43 | Months 4 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER J.W.T.Swinney

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia, W.

12. MAIDEN NAME OF MOTHER Laura Belle Williams

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Mrs Della Swinney
(Address) Marsing, Ida

15. Filed 6-28, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 26 (Month) 1929 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 15th, 1929, to June 26, 1929

that I last saw him alive on June 25, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocarditis, nephritis

..... (duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Hypostatic bronchitis.

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Geo. O. A. Kellogg, M. D.

7/1, 1929 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill | Date of Burial: 6-28 1929

20. Undertaker: P. L. Case | Address: Caldwell Ida.

RECEIVED JUN 28 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66683

PLACE OF DEATH
County of Payette
City of Payette
Registration District No. 4
Primary Registration District No. 1008
(No. 3)
Local Registrar's No. 26

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Hartwell H. Pyle

(a) Residence. No. 129 St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a If married, widowed or divorced
HUSBAND of ~~(or) WIFE of~~ Jennie M Pyle

6 DATE OF BIRTH (month, day and year) Jan 9 1859

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
70	5	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Freight Dispatcher
(b) General nature of industry, business, or establishment in which employed (or employer) G. Northern R R
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10 NAME OF FATHER Aaron Pyle
11 BIRTHPLACE OF FATHER (city or town) (State or country) " "
12 MAIDEN NAME OF MOTHER Lydia A Williamson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant J. M. Pyle
(Address) Spokane, Wash.

15 Filed June 21, 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 20 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to June 20, 1929, that I last saw h~~im~~ alive on June 20, 1929, and that death occurred, on the date stated above, at 11:15 p. m.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis
Parenchymatous
(duration) Several yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Spokane Wash
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical symptoms
(Signed) O. H. Terry, M. D.
June 21, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, ~~Cremation~~, or Removal Spokane Wash — Date of Burial June 22 1929
20 Undertaker D. N. Adair — Address Peterson Furn Co Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 28 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66684

PLACE OF DEATH
County of Fayette
City of Fayette

Registration District No. 4
Primary Registration District No. 1008
(No. ____)
Local Registrar's No. 24

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ernest A Kirk

(a) Residence. No. ____ St. ____

(Usual place of abode)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Nellie M Kirk

6 DATE OF BIRTH (month, day and year) Dec 6 1881

7 AGE: Years 47 | Months 6 | Days 8 | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): ____
(c) Name of employer: ____

9 BIRTHPLACE (city or town) (State or country): Oregon

PARENTS

10 NAME OF FATHER: H A Kirk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mo

12 MAIDEN NAME OF MOTHER: Ayers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Iowa

14 Informant: Nellie M. Kirk.
(Address): Fayette Ida

15 Filed June 17 1929 J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 14 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1904, 19____, to June 14, 1929, that I last saw h~~im~~er alive on June 13, 1929, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ____ yrs. 1 mos. ____ ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) ____ yrs. 7 mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) F R Woodward M. D.

June 15 1929 (Address) Fayette Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Fayette Ida — Date of Burial: June 16 1929

20 Undertaker: O. H. Adams — Address: Peterson Furn Co Fayette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66685

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
(No.)
Local Registrar's No. 23

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wm B Ashlock.

(a) Residence. No. 2373 Seventh St. 40
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	married.

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Viola Ashlock.

6. DATE OF BIRTH (month, day and year) April 19th 1881

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	1	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clergyman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9. BIRTHPLACE (city or town) (State or country) Kansas
10. NAME OF FATHER Francis Parmer Ashlock.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Elizabeth A Redmond
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Mrs. Lee Inman.
(Address) Payette, Idaho.

15. Filed June 15, 1929. J. R. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~1928~~, 1929, to June 12, 1929
that I last saw h~~im~~ alive on June 8, 1929
and that death occurred, on the date stated above, at 11.50 ~~P~~ a.m.
The CAUSE OF DEATH* was as follows:
Mitral regurgitation

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J R Woodward M. D.
6/14, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette Ida.	June 15 1929
20. Undertaker	Address
Jesse C Pardon.	Payette Ida

RECEIVED JUN 28 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

66687

DO NOT WRITE IN THIS SP
State File No. 66687

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
(No.)

Local Registrar's No. 21

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Martha D Allen

131

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug 28 - 1854

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	9	2.	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kan

PARENTS

10 NAME OF FATHER Samuel Hatch
11 BIRTHPLACE OF FATHER (city or town) (State or country) Kans
12 MAIDEN NAME OF MOTHER Rebecca Cooper
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Hugh Allen
(Address) Payette Idaho

15 Filed June 2 1929 J.C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 30 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1929, to May 30, 1929, that I last saw her alive on May 30, 1929, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cardio-renal disease.

indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None.

(Signed) Merrell R. Fox M. D.
May 31, 1929 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Payette Ida	June 1 1929
20. Undertaker	Address
Peterson Furn Co	Payette Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66688

PLACE OF DEATH

County of Payette
City of Payette

Registration District No. 51
Primary Registration District No. 2130
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 1

131

2. FULL NAME Matilde Murphy

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F
4 COLOR OR RACE: W.
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: W. V. Murphy

6 DATE OF BIRTH (month, day and year): Jan 23 1886

7 AGE: Years 43 | Months 4 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kan

PARENTS
10 NAME OF FATHER: W M Jones
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio
12 MAIDEN NAME OF MOTHER: Emma Bowers
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: W V Murphy
(Address): Fruitland Ida

15 Filed June 13, 1929 Mrs Wm T Drysdale Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 9, (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1929, to June 9, 1929, that I last saw her alive on June 9, 1929, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Uremia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Tumor of one kidney and pregnancy (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) W. J. Weese, M. D.
June 12, 1929 (Address) Ontario, Ore

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: New Plymouth | Date of Burial: 6-13 1929

20. Undertaker: J. H. Adair | Address: Peterson Furn Co Payette Ida

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66689

PLACE OF DEATH

County of Power

City of American Falls, Idaho

Registration District No. 25

Primary Registration District No. 2099

Local Registrar's No. 19

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harry Horn

(a) Residence. No. Springfield, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherin Horn

6. DATE OF BIRTH (month, day and year) June 21st 1881

7. AGE	Years	Months	Days	If LESS than 1 day,
	48		7	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS

10. NAME OF FATHER Wm Horn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant B M Carmicle

(Address) Springfield Ida

15. Filed 6/30, 1929 Genevieve Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

By Falling off a load of Poles in a canyon west of Bannock Peak. Front Wheel of wagon passing over hishead

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arv Davis Coroner M. D.

6/29/29, 19 (Address) Am Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Springfield Idaho	6/30/29

20. Undertaker Arv Davis Address American Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66690

PLACE OF DEATH

County of Power

City of American Falls, Idaho

Registration District No. 25

Primary Registration District No. 2072

Local Registrar's No. 18

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME Eva Grace Jones

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: W.N.Jones

6. DATE OF BIRTH (month, day and year): Dec 31 1885

7. AGE: Years 43 | Months 5 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Dayton, Wash.

PARENTS

10. NAME OF FATHER: E.Hatley

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Hanna Stanfield

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: W.N. Jones
(Address) American Falls, Idaho

15. Filed 6-20, 1929 Genevieve Noth Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-17, 1929, to 6-19, 1929 that I last saw her alive on 6-19, 1929 and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows: Tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) V.G. Logan, M. D.

June 20th, 1929 (Address) American Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: I.O.O.F Cemetery

Date of Burial: 19

20. Undertaker: A.W. Davis

Address: American Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66691

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Power — Registration District No. ____

City of American Falls, Ida — Primary Registration District No. ____ (No. ____)

Local Registrar's No. 17

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME George Peter Flemmer

(a) Residence. No. 20 miles west Am Falls. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? 45 yrs. 0 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Paulena Flemmer

6 DATE OF BIRTH (month, day and year): March 30 1838

7 AGE: Years 91 | Months 2 | Days 19 | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer: ____

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Wenzeslaus Flemmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Guliane Unruh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Adolph Winter

(Address) American Falls, Idaho

15 Filed 6-20, 1929 Genevieve Nolt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 18 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 6-17, 1929, to 6-18, 1929, that I last saw h— alive on 6-17, 1929, and that death occurred, on the date stated above, at 1,300 m.

The CAUSE OF DEATH* was as follows: Hemiplegia

____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? None

(Signed) V G Lyon, M. D.

6/19/29, 19__ (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Pleasent Valley Ida. — Date of Burial: 6/21/29 19

20. Undertaker: Aw Davis — Address: American Falls, Ida

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66692

PLACE OF DEATH

County of Power

City of American Falls

Registration District No. 25

Primary Registration District No. 2072

Local Registrar's No. 16

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188e

2. FULL NAME Lisa A Jones

(a) Residence. No. Datyon, Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Jones

6. DATE OF BIRTH (month, day and year) Sept 3rd 1858

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70	9	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Daniel Collett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Folks

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Robert Jones

(Address) Dayton, Idaho

15. Filed 6-11, 1929 Gmenin Noth Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 11th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 9.10 A m.

The CAUSE OF DEATH* was as follows:
Ford Coup in which she was riding did not make the turn just east of Neeley, going west on the Oregon Trail.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fast driving
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A W Davis Coroner, M. D.

6/11/29, 19..... (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Daytonm Ida

Date of Burial: 19

20. Undertaker M W Hendricks Pres. Address American Fall

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66693

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Power

City of Am. Falls

Registration District No. 25

Primary Registration District No. 2072

(No. .....)

Local Registrar's No. 15

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Richard Elmer Zimmermann

74a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 30, 1927

7 AGE: Years: One; Months: 10; Days: 8; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) American Falls Idaho

PARENTS

10 NAME OF FATHER John Zimmermann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Martha M Nachtigal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. D.

14 Informant John Zimmermann
(Address) American Falls Idaho

15 Filed 6-8, 1929 Genevieve Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6 - (Month) 8 - (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 6-7, 1929, to 6-8, 1929, that I last saw him alive on 6-7, 1929, and that death occurred, on the date stated above, at 2:15 a.m.

The CAUSE OF DEATH* was as follows:

Cebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? History &c

(Signed) V G Logan M. D.

6-8, 1929 (Address) American Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: I O O F Cem. Date of Burial: June 8 1929

20. Undertaker: A W Davis Address: Am Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66694

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 20
Primary Registration District No. 1211

Local Registrar's No. 58

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Raymond Earl Betts

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

101a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Elanor Betts

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
38	XX	XX	XX	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B L & L Co.

9. BIRTHPLACE (city or town) (State or country) Stevens Point Wisconsin

PARENTS

10. NAME OF FATHER Walter C Betts
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Mary Wicker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant Grace Elanor Betts
(Address) Smelterville Idaho

15. Filed May 29, 1929 J. K. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 26, 1929
that I last saw him alive on May 26 1929
and that death occurred, on the date stated above, at 4P. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia,
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Kellogg Ida.
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Symptomatology
(Signed) W. L. Quigley, M. D.
5/27, 1929. (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal	Date of Burial
Greenwood Cemetery	May 29 1929
20. Undertaker	Address
M. C. Rankil	Kellogg Ida.

RECEIVED JUN 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66695

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 57

174

2. FULL NAME Ben Johnson
(a) Residence. No. Mullan, Idaho St. Mullan, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 40 Years | Months | Days | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Morning Mine.

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS
10. NAME OF FATHER John Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Karin.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden.

14. Informant Gust Johnson
(Address) Mullan, Idaho.

15. Filed May 26, 1929. J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ___, 19___, to ___, 19___
that I last saw him alive on ___, 19___
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:
Carbolic acid
Phenol poisoning
Suicidal (duration) yrs. mos. ds. few hrs
CONTRIBUTORY (Secondary) Alcoholism
(duration) yrs. mos. ds. several

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? none
(Signed) H. C. Mowry Coroner, M. D.
5/23, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mullan Idaho | Date of Burial May 26 1929

20. Undertaker J. A. Bever Ward Undertaking Co. | Address Wallace, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66696

PLACE OF DEATH

County of Shoshone
City of Kellogg

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 26

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louis Boldue

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1852

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	April		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Dalier County Bellechasse P.Q. Province East Canada

PARENTS

10. NAME OF FATHER Louis Boldue
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Elizabeth Sperrett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs. Mathilde Gratheson
(Address) Kellogg Idaho

15. Filed May 25, 1929 J. R. Livingsley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1929, to May 23, 1929, that I last saw alive on May 22, 1929, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:
Myocarditis Chronic.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma & old age.
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Symptoms & Examination

(Signed) H. C. Lindsay, M. D.
5/23, 1929 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood Cemetery	May 26 1929

20. Undertaker M. C. Shanlee — Address Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. RECEIVED JUN 17 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66697

Local Registrar's No. 55

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. 219 cypress Street St.)

2. FULL NAME Mrs Ina Henderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH: Sept (Month) 16 (Day) 1853 (Year)

7. AGE: 75 Yrs. 6 Mos. 6 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Erie Penn.

10. NAME OF Father: JermiahMurray

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Unice Hill

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Roy H. Kingsbury

(Address) Wallace Idaho

15. Filed May 24 1929 L. K. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 22 (Day) 1929 (Year) 133

17. I HEREBY CERTIFY, That I attended deceased from May 21 1929, to May 22 1929, that I last saw her alive on May 22 1929, and that death occurred on the date stated above, at 9:10 P. M.

The CAUSE OF DEATH* was as follows:

Cholelithiasis (Acute)

(Duration) ....yrs. ....mos. 1 ds.

Contributory (Secondary) Chronic Cholelithiasis

(Duration) ....yrs. 6 years mos. ....ds.

(Signed) James R Dean M. D.

5/23/1929 (Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane wash. DATE OF BURIAL: 5/24/29 19....

20. UNDERTAKER: Worstell Co ADDRESS: Wallace

J. S. Shaughnessy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED JUN 17 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66698

Local Registrar's No. 54

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. Wallace Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Sawaski

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Singles (Write the word)

6. DATE OF BIRTH: (Month) (Day) 1891 (Year)

7. AGE: 38 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer): Hecla Mining Co,

9. BIRTHPLACE (State or Country): Rissia

10. NAME OF Father: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Supt Wallace Hospital

(Address) Wallace Idaho

15. Filed May 23 1929 S. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17 (Day) 1929 (Year) 201

17. I HEREBY CERTIFY, That I attended deceased from May 11 1929, to May 16 1929, that I last saw him alive on May 16 1929 and that death occurred on the date stated above, at 2:00 A. M.

The CAUSE OF DEATH* was as follows:

Skull Fracture (Basil)

(Duration) yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. H. Werlich M. D.

May 21 1929 (Address) Wallace-Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Kellogg Idaho

DATE OF BURIAL: 5/23/ 1929

20. UNDERTAKER: Worstell Co J. P. Shaughnessy

ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. [illegible]. RECEIVED JUN 17 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66699

Local Registrar's No. 52

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1011

(No. Wallace Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Timco

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: April (Month) 2 (Day) 1892 (Year)

7. AGE: 37 Yrs. 1 Mos. 1 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer): Hecla Mine, Burke Idaho

9. BIRTHPLACE (State or Country): Roumania

10. NAME OF Father: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Roumania

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Roumania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Laura Stine

(Address) Burke Idaho

15. Filed May 8 1929 F. R. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 1929 to May 2 1929 that I last saw him alive on May 2 1929 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Retropharyngeal abscess

(Duration) ....yrs. ....mos. 12 ds.

Contributory (Secondary) Pyemia

(Duration) ....yrs. ....mos. 10 ds.

(Signed) Arthur C. Jordan M. D.

May 6 1929 (Address) Wallace, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: United Cem, Wallace Ida — DATE OF BURIAL: 5/8 1929

20. UNDERTAKER Worstell Co J S Straughnessy — ADDRESS Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1929

PLACE OF DEATH

County of Shoshone

City of Mullan

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66700

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 51

(No. Hunter Mine)

(If death occurred in a hospital or institution, give its name instead of street and number.)

186

2. FULL NAME Melvin Noll

(a) Residence. No. ..... St. Mullan, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 26 - 1905

7. AGE Years 23 Months 4 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gold Hunter Mng. Co.

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10. NAME OF FATHER Archie Noll

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mrs Jack Leonard
(Address) Mullan, Idaho

15. Filed May 7, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 3, 1929

that I last saw him alive on May 3, 1929

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows: Accidentally Killed Broken neck & Back and skull

(duration) Instant. ds.

CONTRIBUTORY (Secondary) Falling through Muck Pile

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination.

(Signed) F. L. Quigley, M. D.

5/4, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Gooding, Idaho. Date of Burial May 7 1929

20. Undertaker J. A. Bever Ward Und Co. Address Wallace, Idaho

RECEIVED JUN 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66701

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1011
(No. Nine Mile Road)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 50

2. FULL NAME Ruby McDowell

(a) Residence. No. NOne Mile Road St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

748

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Z.A.McDowell

6 DATE OF BIRTH (month, day and year) Feb. 17 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	52	2	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER William Cannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Laura Twain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant Z.A.McDowell
(Address) Wallace Idaho

15 Filed May 5, 1929 J. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 3 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1929, to May 3, 1929, that I last saw h[illegible] alive on May 2, 1929, and that death occurred, on the date stated above, at 12:0a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ____ yrs. 1 mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James R Dean, M. D.

5/4, 1929 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
United Cemetery Wallace Ida.	5/5/29
20. Undertaker Worstell Co	Address Wallace Ida

J. D. Shaughnessy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66702

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 10
Primary Registration District No. 1011
(No. Providence Hospital)
Local Registrar's No. 49
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Richard A. McVitty

(a) Residence. No. Mullan Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of Ida McVitty
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan 1.1854

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10 NAME OF FATHER Not Known
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Ida McVitty
(Address) Mullan Idaho

15 Filed May 3, 1929 F. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 2 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 30, 19..., to May 2, 19..., that I last saw h.m alive on May 2 -, 19..., and that death occurred, on the date stated above, at 9 a.m. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Nephritis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) F L Jenkins, M. D.
5/3, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Tamworth Ontario Canada	
20 Undertaker Worstell Co	Address Wallace Ida.

J P Shaughnessy

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66703

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 32

100a

2. FULL NAME Allan Albert Capaul

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1927-5-27

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
2	0	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur d'Alene Ida.

PARENTS

10. NAME OF FATHER Geo. Capaul
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Troy. Ida.
12. MAIDEN NAME OF MOTHER Frances Palchen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Seattle. Wa.

14. Informant Mrs George Capaul
(Address) Kellogg Idaho

15. Filed June 10, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3rd, 1929, to June 10, 1929
that I last saw him alive on June 9th, 1929,
and that death occurred, on the date stated above, at 3:20 a. m.
The CAUSE OF DEATH* was as follows:
Bronchia pneumonia
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Symptomatology
(Signed) W. C. Lindsay, M. D.
6/10, 1929, (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Coeur d'Alene Ida
Date of Burial: 6-12 1929

20. Undertaker: Cassedy Funeral Home
Address: C D Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66704

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. 170)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 31

2. FULL NAME Frank Tasson

(a) Residence. No. Pleasant Home St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 1-1856

7. AGE	Years	Months	Days	If LESS than 1 day,
	73		4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dont Know

PARENTS

10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Frank Kenyon
(Address) Mullan Ida

15. Filed June 30, 1929 Mrs. Helen M. Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on June 4, 1929, to ....., 19....
that I last saw ~~him~~ alive on June 4, 1929
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Revolver wounds of head
suicidal
Instantly fatal (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Inspection

(Signed) Leon H Kennett, M. D.
June 5, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverside Wash. Date of Burial: June 1 1929
20. Undertaker: R. L. Stout Address: Kellogg Ida

Bennett

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66705

Local Registrar's No. 30

PLACE OF DEATH

County of Shoshone

City of Kellogg

Registration District No. 123

Primary Registration District No. 2201

(No. 161a) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Burch

(a) Residence. No. [illegible] Kellogg, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 4, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Kellogg Idaho
(State or country)

PARENTS

10. NAME OF FATHER Wm. A. Burch

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Eva Hallestad

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) N. Dakota

14. Informant Wm. A. Burch
(Address)

15. Filed June 30, 1929 Mrs. Helen M. Bride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from on
, 19, to , 19
that I last saw her alive on June 4, 1929
and that death occurred, on the date stated above, at 7:50 a.m.

The CAUSE OF DEATH* was as follows:
Premature birth

(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Geo. T. Kennett, M. D.

June 7, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Idaho	June 5, 1929
20. Undertaker M. C. Thornhill	Address Kellogg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66706

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 27

2. FULL NAME Robert Mason Crockwell 24

(a) Residence. No. Kellogg Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 19 - 1921

7. AGE: Years 8 1921; Months 5 July; Days 19 11; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg Idaho

PARENTS

10. NAME OF FATHER Earl M Crockwell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City Utah
12. MAIDEN NAME OF MOTHER Lavrie Butze
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia City Nevada

14. Informant Earl M Crockwell
(Address) Kellogg Ida

15. Filed June 30, 1929. Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13, 1929, to May 27, 1929
that I last saw him alive on May 26, 1929
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:
Meningococcus Meningitis
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. 1 mos. 14 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) T. R. Mason, M. D.
May 30, 1929 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg Ida
Date of Burial: May 29 1929

20. Undertaker: R. L. Stout
Address: Kellogg

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66707

PLACE OF DEATH

County of Shoshone

City of Kellogg, Ida.

Registration District No. 90

Primary Registration District No. 1050

Local Registrar's No. 90

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Astrid G. Johnson 31

(a) Residence. No. Kellogg, Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fe.	White	married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of E. G. Johnson

6. DATE OF BIRTH (month, day and year) 1 1 [illegible]

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER No information

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER No information.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant E G Johnson

(Address)

15. Filed 6/27, 1929. K. J. Sturgee Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8, 1929, to June 11, 1929

that I last saw her alive on June 11, 1929

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Kellogg, Idaho

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Myers, M. D.

June 13, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood Cemetery Kellogg, Idaho	6/14/29 19

20. Undertaker L. C. Thornhill

Address Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66708

PLACE OF DEATH
County of Teton
City of Felt
Registration District No. 77
Primary Registration District No. 2176
Local Registrar's No. 17
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Hendrickson

(a) Residence. No. Felt Idaho St. Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Angeline Hendrickson

6. DATE OF BIRTH (month, day and year) Aug 29 - 1868

7. AGE	Months	Days	If LESS than 1 day,
60 Years	~~Aug.~~ 9	15	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Farmington Utah

PARENTS

10. NAME OF FATHER James Hendrickson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Martha Jane Langley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Texas

14. Informant Jesse Hendrickson
(Address) Felt, Idaho.

15. Filed 6-29-, 1929. Martha Marker Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-13, 1929, to 6-13, 1929
that I last saw ~~him~~ alive on —, 19
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart Sudden
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Mitral Insufficiency
(duration) 2 yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. C. Parkinson, M.D.
6-13, 1929 (Address) Driggs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Felt Idaho	6-15- 1929
20. Undertaker	Address
—	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 3 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66709

County of Teton
City of Felt
Registration District No. 77
Primary Registration District No. 2176
(No.)
Local Registrar's No. 15

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Faye Dennis Ricks

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Francis S Ricks

6 DATE OF BIRTH (month, day and year) 11-3-1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	7	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Oklahoma

PARENTS

10 NAME OF FATHER Robert M. Ridley
11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky
12 MAIDEN NAME OF MOTHER Georgia Arnall
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Missouri

14 Informant Francis S. Ricks
(Address) Felt, Idaho

15 Filed 6-13-, 1929 Martha Marker Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 4 (Day) 1929 (Year)

17 I HEREBY CERTIFY, ~~That I attended deceased from~~ , 19 , to , 19 ,
that I last saw h alive on , 19 ,
and ~~that death occurred, on the date stated above, at~~ 4:30 P. m.

The CAUSE OF DEATH* was as follows:
Struck by Lightning
No Medical Attention Available
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C E Eckersell M. D.
June 5, 1929 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Rexburg Ida.	6/8 1929
20. Undertaker	Address
C E Eckersell	Rexburg

RECEIVED JUL 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66710

PLACE OF DEATH
County of Teton
City of Victor

Registration District No. 77
Primary Registration District No. 2176
(No.)
Local Registrar's No. 16

(If death occurred in a hospital or institution, give its name instead of street and number.)

64

2. FULL NAME Edward McDonald

(a) Residence. No. Victor Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Myrle McDonald.

6. DATE OF BIRTH (month, day and year) May 4 1888.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	1	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Heber. Utah

PARENTS

10. NAME OF FATHER Wm McDonald
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.
12. MAIDEN NAME OF MOTHER Elizabeth Shutts.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Mrs. Myrle McDonald
(Address) Victor, Idaho.

15. Filed 6-13-, 1929 Martha Marker Registrar
per Pauline

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11, 1929, to June 11, 1929
that I last saw him alive on , 19
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
acute alcoholic poisoning

(duration) hrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. C. Parkinson M. D.
June 12, 1929 (Address) Driggs Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Provo Utah	
20. Undertaker	Address
Goff Hazen	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66713

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No. County General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Edwin Parker Griffith

(a) Residence. No. 227 Second Ave South Twin Falls St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 1St 1852

7. AGE	Years	Months	Days	If LESS than 1 day,
	77	5	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) PA.

PARENTS

10. NAME OF FATHER John Griffith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Elizabeth Parker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant N. F. Griffith
(Address) 712½ Idaho St. Boise

15. Filed 7-10, 1929 N. M. Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 11Th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1929 to June 11, 1929
that I last saw him alive on June 11, 1929
and that death occurred, on the date stated above, at 12 A m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) G. S. Weaver, M. D.
6/11, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Butler, Missouri.	19

20. Undertaker	Address
P.J. Grossman,	Twin Falls, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66714

PLACE OF DEATH

County of Twin Falls

City of " "

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No.

(No. Co Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Wallace Scot Nelson

(a) Residence. No. Oakley Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 26 1901

7. AGE Years 27 Months 11 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stockman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER L. A. Nelson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Anna Worthington

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Ross Nelson
(Address) 511 4th ave No. Twin Falls

15. Filed 7-10, 1929 H. N. Leek Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11, 1929, to June 12, 1929 that I last saw him alive on June 12, 1929 and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Nevada

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) John R Morgan, M. D.

6/13, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Oakley

Date of Burial: June 14 1929

20. Undertaker: J J Grossman

Address: T. F.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66715

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. Co Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Juana Domingez - Juana Dominguez Rosco 46

(a) Residence. No. Murtaugh St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Unknown 1885

7. AGE: 44 Years | Months | Days | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mexico

PARENTS

10. NAME OF FATHER: Gustino Palina
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mexico
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mexico

14. Informant: Luz Palina
(Address): Murtaug

15. Filed 7-10, 1929 H N [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18 (Day) 1929 (Year) 4-30

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to June 18, 1929
that I last saw her alive on June 17, 1929
and that death occurred, on the date stated above, at 4:30 A m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus
probably (duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary): Septic Parotitis
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? California
Did an operation precede death? Yes Date of 6/?/28
Was there an autopsy? No
What test confirmed diagnosis? Manual exam
(Signed) J N Davis, M. D.
6/18, 1929 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer Cemetary | Date of Burial: June 19 1929

20. Undertaker: F E Drake | Address: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66716

PLACE OF DEATH
County of Twin Falls
City of Twin Falls.

Registration District No. 37
Primary Registration District No. 1085

Local Registrar's No.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles L. Roberts

(a) Residence. No. 172 Lois St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ettie M. Roberts

6. DATE OF BIRTH (month, day and year) Aug 30 - 1858

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	9	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Surveyor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Adams Co. (State or country) Ohio

PARENTS

10. NAME OF FATHER John Roberts

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Booth

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Mrs. Ettie M. Roberts
(Address) 172 Lois St.

15. Filed 7-10, 1929 H. N. Lee Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 18, 1929
that I last saw him alive on June 17, 1929
and that death occurred, on the date stated above, at 3:30 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of rectum

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) C. D. Weaver, M. D.
6/19, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	June 19 1929
20. Undertaker	Address
White Mortuary Inc	Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 10 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 66717

Local Registrar's No. .....

74

2. FULL NAME Mrs Lilya Alavon Olson

(a) Residence. No. 1437--4Th. Ave. East St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 3Rd. 1904

7. AGE	Years	Months	Days	If LESS than 1 day,
	25	3	9	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Thomas A. Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Celia Dees,

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Thomas A. Smith
(Address) 344 Wash. Ave, So.

15. Filed 7-10, 1929 N. N. Leete
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June, 12Th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-12-, 1929, to 6-12-, 1929 that I last saw h-er alive on June 12-, 1929 and that death occurred, on the date stated above, at 630 PM.

The CAUSE OF DEATH* was as follows:

Epileptic Seizure

(duration) ..... yrs. ..... mos. 10 hrs.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hx and

(Signed) N. N. Leete, M. D.

6-24-, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Idaho	June, 15Th 1929

20. Undertaker P.J. Grossman Address Twin Falls,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 10 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66718

Local Registrar's No.

164

2. FULL NAME Elizabeth Cutler

(a) Residence. No. 1401 (Usual place of abode) Addison E St.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FeMale	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug, 9 1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	10	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Barnes Timble

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind,

12. MAIDEN NAME OF MOTHER Elizabeth Scott

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant B, T, Cutler

(Address) Twin Falls

15. Filed 7-10, 1929 H. M. Little Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June, 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22, 1929, to June 22, 1929
that I last saw h[illegible] alive on June, 1929
and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Senility (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F, F, Drake Coroner, M. D.

6-22-, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mc; Cracken Nebr	19

20. Undertaker	Address
F, F, Drake	Twin Fal

RECEIVED JUL 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66719

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
County Hospt

Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME J. J. Bradford

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant J. E. Drake
(Address) Twin Falls

15. Filed 7-10, 1929 H. N. Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 20 1, am 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1929 to June 20, 1929
that I last saw him alive on June 19, 1929
and that death occurred, on the date stated above, at 1 a. m.
The CAUSE OF DEATH* was as follows: Rocky Mountain Spotted Tick Fever.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. D. Weaver M. D.
6/21, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer Cemetery — Date of Burial: June 24 1929

20. Undertaker J. E. Drake — Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66720

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 1085
(No. Co. Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Mary Etta Detweiler

(a) Residence. No. 127 9th Ave No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

70

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: D. F. Detweiler

6. DATE OF BIRTH (month, day and year): Oct. 9 1866

7. AGE: Years 62, Months 8, Days 9. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10. NAME OF FATHER: John D. Hunshofer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pa.
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pa.

14. Informant: D. T. Detweiler
(Address) 127 9 ave No City

15. Filed 7-10, 1929 H. N. Lee Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Deed June 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1929, to June 18, 1929
that I last saw her alive on June 18, 1929
and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:
Encephalitis with Paresis of neck muscles & right side
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Influenza & Epilepsy
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) John R. Morgan M. D.
6/18, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: June 20 1929

20. Undertaker: P. J. Grossman
Address: Twin Falls

FORM V. S. No. 5-25 M. 1-19

RECEIVED JUL 10 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Filer

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 2085

(No. ..... St.)

File No. 66721

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Flay Stees

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: March (Month) 4 (Day) 1893 (Year)

7. AGE: 36 Yrs. 3 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) Wife

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER G. B. Logan

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Martha Parks

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. B. Logan

(Address) Twin Falls

15. Filed 10 1929 H. N. Leete Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 26 (Day) 1929 (Year)

44 8.00

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1926, to June 26 1929, that I last saw her alive on April 1st 1929, and that death occurred on the date stated above, at 7 a. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Metastatic (following Amputation Breast) Liver

(Duration) 3 Yrs. ✓ mos. ✓ ds.

Contributory (Secondary) Carcinoma-Pelvic bones

(Duration) 1 yrs. 6 mos. ✓ ds.

(Signed) Duncan L. Alexander M. D.

6/27/29 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer, Cemetery

DATE OF BURIAL: June 28 1929

20. UNDERTAKER: F. E. Drake

ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JUL 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66722

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

Registration District No. 3-7
Primary Registration District No. 1085
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Lucien W. Voorhees

(a) Residence. No. 104 Lincoln St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edith A. Voorhees

6. DATE OF BIRTH (month, day and year) Jan

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
41	5	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Automobile Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Chicago Ill.
(State or country)

PARENTS

10. NAME OF FATHER Leslie P. Voorhees

11. BIRTHPLACE OF FATHER (city or town) Beloit
(State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Mary R Whitman

13. BIRTHPLACE OF MOTHER (city or town) Watertown
(State or Country) Mass.

14. Informant L. P. Voorhees
(Address) Chicago Ill.

15. Filed 7-10, 1929 F. M. Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14th, 1929 to June 26, 1929
that I last saw him alive on June 25th, 1929
and that death occurred, on the date stated above, at 4 15 P m.

The CAUSE OF DEATH* was as follows:

Embolism Cerebral

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 6 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H E Lamb, M.D.

June 27, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls.	6/28 1929
20. Undertaker	Address
White Mortuary	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-10

RECEIVED JUL 10 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Twin Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ..... , ... St.)

File No. 66724

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Ellis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: March (Month) 25 (Day) 1884 (Year)

7. AGE: 45 Yrs. 3 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Emanuel Watts

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Della Thompson

(Address) Twin Falls 186 Sidney

15. Filed 7-10 1929 H. N. Leeds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1928, to June 30th 1929 that I last saw her alive on June 30th 1929, and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows: Cancer of uterus

(Duration) Two Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John W. Coughlin M. D.

7-3 1929 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls DATE OF BURIAL: July 3 1929

20. UNDERTAKER: F. E. Drake ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-28

RECEIVED JUL 10 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2085
File No. 66725
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Berger
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlotte Fleming

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: July 29 (Month) (Day) 1894 (Year)

7. AGE: 35 Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer): Wife

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: C M. Bussford

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Lizzie Marler

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dan Fleming
(Address) Twin Falls

15. Filed 7-10 1929 H N Leete Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 2 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1929 to July 3 1929 that I last saw her alive on July 1929, and that death occurred on the date stated above, at 11 A M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrage
(Duration) 7 Yrs. — mos. — ds.
Contributory (Secondary) Subject to Convulsions
(Duration) 10 yrs. — mos. — ds.
(Signed) F. L. Drake Coroner M. D.
July 19 29 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer — DATE OF BURIAL: July 5 1929

20. UNDERTAKER: F. L. Drake — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66726

PLACE OF DEATH
County of Twin Falls
City of Co Hospital

Registration District No. 39
Primary Registration District No. 2087
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

41

2. FULL NAME Ruth C. Miller

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or ~~Divorced~~ (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Victor Miller

6. DATE OF BIRTH (month, day and year) May 10-1909

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
20	1	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sage, Iowa

PARENTS

10. NAME OF FATHER L. W. Loveless.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Isadora E. Cowen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant Mrs L. W. Loveless
(Address) Buhl Ida

15. Filed June 24, 1929. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11th, 1929, to June 23rd, 1929
that I last saw her alive on June 23, 1929
and that death occurred, on the date stated above, at 12,03 P m.
The CAUSE OF DEATH* was as follows:
Septicemia

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Gangrenous Appendicitis
..... (duration) ..... yrs. ..... mos. 16 ds.

18. Where was disease contracted if not at place of death? at 1 Hour
Did an operation precede death? Yes Date of June 11th 29
Was there an autopsy? No
What test confirmed diagnosis? Yes
(Signed) R. E. Stewart, M. D.
June 24, 1929 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Ida — Date of Burial 6/25 1929

20. Undertaker L. J. Johnson — Address Buhl

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66727

PLACE OF DEATH
County of Twin Falls
City of Castleford
Registration District No. 39
Primary Registration District No. 2087
Local Registrar's No.
(No. 204)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Phillip Boyington Hardy

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Katherine Hardy

6. DATE OF BIRTH (month, day and year) Apr 21 1870

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	1	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Ida.

PARENTS

10. NAME OF FATHER Geo. C. Hardy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boston Mass
12. MAIDEN NAME OF MOTHER Mary H. Swan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pennsylvania

14. Informant Del Hardy
(Address) Contact Nev.

15. Filed June 20, 1929 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Died Suddenly
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Heart Disease
Not Known (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Not Known
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) J. H. Murphy, M. D.
6-20, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl, Ida	June 18 1929

20. Undertaker L. J. Johnson — Address Buhl. Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66728

PLACE OF DEATH
County of Twin Falls
City of T. F. C. Hospital

Registration District No. 39
Primary Registration District No. 2087
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Lavina Olivia Barran 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Barran

6. DATE OF BIRTH (month, day and year) March 20 1860

7. AGE Years 69 Months 2 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10. NAME OF FATHER Mr. - - - George
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Harry Kinter
(Address) Buhl, Ida.

15. Filed 6-11, 1929. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to June 10, 1929
that I last saw her alive on June 10, 1929
and that death occurred, on the date stated above, at 11-20 P.m.
The CAUSE OF DEATH* was as follows:
Valvular lesion of heart.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) "Flue"

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? At home.
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Clinical.
(Signed) J. H. Murphy M. D.
June 11, 1929 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Ida — Date of Burial 6/12 1929

20. Undertaker L. J. Johnson — Address Buhl Ida

FORM V. S. No. 5-A—25 M. 1-19

RECEIVED JUL 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls.

City of Twin Falls.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39

Primary Registration District No. 2087

(No. ..... St.)

File No. 66729

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Luis Angoitia

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: — (Month) — (Day) 1892 (Year)

7. AGE: 37 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stockman

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Gose Antonio

11. BIRTHPLACE OF FATHER (State or Country): Spain.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Tomasa Angoitia

(Address) Mountain Home Idaho

15. Filed June 6 1929

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) — 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-24 1929, to 6-5- 1929, that I last saw him alive on 6-5- 1929, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH*, was as follows:

Acute dilatation of Heart

Spotted Fever

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Lobar Pneumonia

Spotted Fever - 11 days

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Geo. Jennings M. D.

6-6 1929 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Ida

DATE OF BURIAL: 6-8 1929

20. UNDERTAKER: White Mortuary

ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66730

PLACE OF DEATH
County of Twin Falls
City of
Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

161B

2. FULL NAME Baby Niichel

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, 16 hrs. or min.
	—	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burke Ida.

PARENTS

10. NAME OF FATHER John Niichel
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Elizabeth Hagen.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant John Niichel
(Address) Burke

15. Filed 6-3-, 1929 J. F. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth to death
, 19, to , 19
that I last saw h alive on 1st June, 1929
and that death occurred, on the date stated above, at 5:00 m.
The CAUSE OF DEATH* was as follows:
Atelectasis

(duration) from birth yrs. mos. ds.
CONTRIBUTORY (Secondary) Malposition in utero
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? inability to inflate lungs
(Signed) J. W. MacMaster M. D.
, 19 (Address) Burke, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burke, Ida	June 2 1929
20. Undertaker L. D. Johnson	Address Burke Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 6 1929

PLACE OF DEATH

County of Twin Falls

City of Hospital

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 39

Primary Registration District No. 2087

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66731

Local Registrar's No. .....

101a

2. FULL NAME Max Lavaugh Hobson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 16 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Jan. 27-1928

7. AGE Years 1 Months 4 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buhl, Ida.

PARENTS

10. NAME OF FATHER Chester Hobson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Sarah Bristow

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tennessee

14. Informant Chester Hobson

(Address) Buhl, Ida.

15. Filed 6. 3. 1929. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to June 1, 1929 that I last saw him alive on June 1, 1929 and that death occurred, on the date stated above, at 3.05 P m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia.

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Tonsilitis. Enter-Colitis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Yes.

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. H. Murphy, M. D.

6-3-, 1929 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl, Ida. Date of Burial June 2 1929

20. Undertaker L. Johnson Address Buhl Ida

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66732

PLACE OF DEATH
County of Twin Falls
City of Murtaugh

Registration District No. 36
Primary Registration District No.
(No. at home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

2. FULL NAME Sarah Ann Moyes 90
(a) Residence. No. Murtaugh Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of W. G. Moyes

6. DATE OF BIRTH (month, day and year) Dec 15 1865

7. AGE Years 63 Months 6 Days 10 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hyrum Utah

PARENTS
10. NAME OF FATHER Alanson Allen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont.
12. MAIDEN NAME OF MOTHER Chastina Stadlock
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vt.

14. Informant W. G. Moyes
(Address) Murtaugh

15. Filed 6/26, 1929 J. M. Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1928, to June 25, 1929
that I last saw her alive on June 20, 1929
and that death occurred, on the date stated above, at 8:25 A.M.
The CAUSE OF DEATH* was as follows:
Cardio-Vascular disease
(duration) 20 yrs. mos. ds.
CONTRIBUTORY (Secondary) Toxic thyroid
(duration) 20? yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. M. Davis, M. D.
6-26, 1929 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial June 27 1929
20. Undertaker J. J. Grossmann
Address Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66733

Local Registrar's No. 8

PLACE OF DEATH

County of Twin Falls
City of Kimberly
Registration District No. 36
Primary Registration District No.
(No. Kimberly)
(If death occurred in a hospital or institution, give its name instead of street and number.)

748

2. FULL NAME Mrs, Johanna F. Thieme

(a) Residence. No. Kimberly, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 11th 1858

7. AGE 70 Years | 6 Months | 23 Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10. NAME OF FATHER John Gruen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Henig

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant C.F. Thieme
(Address) Kimberly Idaho.

15. Filed June 3, 1929 J.M. Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 3 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to June 3, 1929
that I last saw h alive on June 2, 1929
and that death occurred, on the date stated above, at 9 A m.
The CAUSE OF DEATH* was as follows:
Apoplexy

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J.M. Davis, M. D.
June 3, 1929 (Address) Kimberly Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Idaho,	June 5th 1929
20. Undertaker P.J. Grossman	Address Twin Falls,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-10-18

RECEIVED JUL 16 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Valley

City of McCall

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. ....., ... St.)

File No. 66734

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob Stover

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed (Write the word.)

6. DATE OF BIRTH. June (Month) 24 (Day) 1848 (Year)

7. AGE 80 Yrs. 10 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner

(b) General nature of industry, business, or establishment in which employed (or employer)..

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Jacob Stover

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roy Stover

(Address) McCall Ida.

15.

Filed ..... 191 Stella Cain Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 164 Apr. (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1 1928, to Apr 26 1929, that I last saw him alive on Apr 25 1929, and that death occured on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Heart failed.

(Duration 2 yrs. ..... mos. ..... ds.

(Signed) D. [illegible] M. D.

19..... (Address) McCall Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191

20. UNDERTAKER | ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUN 18 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 15

Primary Registration District No.

File No. 66735

County of Valley

City of Cascade Idaho (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Ann Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (or Married, Widowed, Divorced)

6. DATE OF BIRTH: May (Month) 24 (Day) 1928 (Year)

7. AGE: / Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Cascade Idaho

10. NAME OF FATHER: John Williams

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Ethel Jordan

13. BIRTHPLACE OF MOTHER (State or Country): Star Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs John Williams

(Address) Cascade Idaho

15. Filed 19 Stella Cain Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1929 to May 24 1929 that I last saw her alive on May 23 1929 and that death occurred on the date stated above, at 5 00 A.M.

The CAUSE OF DEATH* was as follows:

Whooping cough

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary) Pneumonia

(Duration) yrs. mos. 5 ds.

(Signed) Forrest C Ward M. D.

5/24 1929 (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cascade Idaho — DATE OF BURIAL 19

20. UNDERTAKER: Wm M Bradbury — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUL 16 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Valley

City of Roseberry

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. ....., ... St.)

File No. 66736

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Terry Wm Barker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Sept (Month) 19 (Day) 1904 (Year)

7. AGE 24 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Forest Service

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Roseberry

10. NAME OF FATHER Wm Barker

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Amy Boydson

13. BIRTHPLACE OF MOTHER (State or Country) Kans

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. C. Barker

(Address)

15. Filed ..... 191 Stella Cain Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1929, to June 9 1929, that I last saw him alive on June 9 1929, and that death occured on the date stated above, at 1.22 M.

The CAUSE OF DEATH* was as follows:

Spotted (Tick) Fever

(Duration) ..... Yrs. about 14 mos. ..... ds.

Contributory (Secondary) Enteric infection & liver stasis

(Duration ..... yrs. about 10 mos. ..... ds.

(Signed) Roy F. Munters M. D.

19..... (Address) McCall, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Payette river above Falls.

Former or usual residence Roseberry, Ida.

19. PLACE OF BURIAL OR REMOVAL Roseberry Idaho

DATE OF BURIAL June 11 1929

20. UNDERTAKER Wm McBrabney A.D.R.

ADDRESS Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 1 1929

PLACE OF DEATH

County of Washington

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1010

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66737

Local Registrar's No. 35

164

2. FULL NAME Francis Elizabeth Wills

(a) Residence. No. E Court St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE Wht

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Jas Wills

6. DATE OF BIRTH (month, day and year) Nov 30-1849

7. AGE Years 79 Months 5 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ~~Housewife~~ wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Center point Arkansas

PARENTS

10. NAME OF FATHER Benj F. Jones

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Nancy Miller

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Va

14. Informant Mrs Tim Boston

(Address) Weiser Ida

15. Filed June 28, 1929. W. R. Hamilton Registrar

M H M.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1929, to May 23, 1929

that I last saw her alive on May 4, 1929

and that death occurred, on the date stated above, at 7:30 a m.

The CAUSE OF DEATH* was as follows:

senility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Focal Infection & teeth

..... (duration) 5 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) F A Schmidt, M. D.

5-23, 1929 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hillcrest Cemetery — Date of Burial: 5-24-1929

20. Undertaker: L. C. Northam — Address: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66738

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 56.
Primary Registration District No. 1010
Local Registrar's No. 34

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

188 c

2. FULL NAME Lloyd John White

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 26 - 1920

7. AGE: 8 Years, Months 7, Days 23. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Emmett Idaho

PARENTS

10. NAME OF FATHER: John H. White
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Arkansas
12. MAIDEN NAME OF MOTHER: Dora M. Whiteaker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wyoming

14. Informant: John H White
(Address) Emmett Idaho

15. Filed May 19, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Automobile accident, died before Doctor arrived Fracture base of skull
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L. C. Northam Coroner
May 20, 1929 (Address) Weiser, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Ida
Date of Burial: 5/22 1929

20. Undertaker: C D Bucknum
Address: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 1 1929

PLACE OF DEATH

County of Washington

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1010

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66739

Local Registrar's No. 33

98a

2. FULL NAME Flora Caroline Leavell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE Wht

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 6 - 1913

7. AGE Years 16 Months 1 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho

PARENTS

10. NAME OF FATHER O.R. Leavell

11. BIRTHPLACE OF FATHER (city or town) Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Grace A McElroy

13. BIRTHPLACE OF MOTHER (city or town) Oregon
(State or Country)

14. Informant Dr O.R. Leavell
(Address) Weiser Ida

15. Filed June 28, 1929 W. R. Hamilton M.H.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Ap. 1, 1929, to May 27, 1929 that I last saw her alive on May 27, 1929 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

..... (duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. M. Marshall M. D.

May 28, 1929 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Nampa. Idaho — Date of Burial 5-30-1929

20. Undertaker L. C. Northam — Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 1 1929

PLACE OF DEATH

County of Washington

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1010

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66740

Local Registrar's No. 32

2. FULL NAME Martha B. Bohrer

(a) Residence. No. 913 W. 1st st St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

129

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE Wht

5. Single, Married, Widowed, or Divorced (write the word) widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of David Bohrer

6. DATE OF BIRTH (month, day and year) Aug. 7 - 1856

7. AGE Years 72 Months 9 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelbyville Mo

PARENTS

10. NAME OF FATHER William F Blackburn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Charlotte Meddox

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant Mrs E. H. Goley

(Address) Weiser, Idaho

15. Filed June 28, 1929 W. R. Hamilton Registrar

M H M

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1922, to May 20, 1929

that I last saw her alive on May 20, 1929,

and that death occurred, on the date stated above, at 6:45 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chronic Interstitial Nephritis Hyperarterial Tension.

..... (duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Apoplexia

..... (duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Paralysis -

(Signed) Frank O Finney, M. D.

5/20, 1929 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hillcrest Cemetery — Date of Burial: 5-22-1929

20. Undertaker: L. C. Northam — Address: Weiser Ida

RECEIVED JUL 1 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66741

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 31

(No. 164) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Bareaud

(a) Residence. No. Poor Farm St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 26-1840

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
89	2	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Falkirk
(State or country) Scotland

PARENTS

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Dont Know

14. Informant Manager Poor Farm
(Address) Weiser. Ida

15. Filed June 28, 1929 W. R. Hamilton Registrar
M.H.M.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1926, to June 5th, 1929
that I last saw h[illegible] alive on June 5th, 1929
and that death occurred, on the date stated above, at 3 a. m.
The CAUSE OF DEATH* was as follows:
Senility
(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) L. L. Barnard, M. D.
6/6/29, 19 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellerest Cemetery	6-6-1929
20. Undertaker L. L. Northam	Address Weiser Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66742

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 30

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Helen A Frisby
(a) Residence. No. 1412 Kenilworth Ave. Cleveland. Ohio.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 25-1859

7. AGE Years 70 Months 3 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Former Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cleveland Ohio

PARENTS
10. NAME OF FATHER Richard Frisby
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Eliza Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y.

14. Informant Lillian H. Woods
(Address) 1412 Kenilworth Ave. Cleveland Ohio

15. Filed June 28, 1929 W. R. Hamilton Registrar
MHM

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~April~~ May 4th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29th, 1929, to May 4th, 1929
that I last saw her alive on May 4th, 1929
and that death occurred, on the date stated above, at 11.30 A.m.
The CAUSE OF DEATH* was as follows:

Pneumonia embolism
..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) mitral regurgitation
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E. C. Hiatt, ~~M.~~ D.O.
May 7th, 1929 (Address) Weiser, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Cleveland. Ohio
Date of Burial 19

20. Undertaker L. C. Northam
Address Weiser, Ida

RECEIVED JUL 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66743

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 29

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louisa Cooper

(a) Residence. No. 900 E Main St. 90
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	Widowed

5a. If married, widowed, or divorced
~~HUSBAND~~ or (or) WIFE of S. B. Cooper

6. DATE OF BIRTH (month, day and year) Apr 16 1849

7. AGE	Years	Months	Days	If LESS than 1 day,
	80	1	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS

10. NAME OF FATHER Charles Cooper
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky
12. MAIDEN NAME OF MOTHER Campbell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Lizzie Cooper
(Address) Weiser. Idaho

15. Filed June 8, 1929 W. R. Hamilton Registrar
M N M.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Several years ago, 19..., to May 10, 1929
that I last saw her alive on May 9 1929
and that death occurred, on the date stated above, at 4 A m.
The CAUSE OF DEATH* was as follows:

Mitral regurgitation
Several (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? don't know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical symptoms
(Signed) G. M. Hutchison, M. D.
May 11, 1929 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	5-12-1929
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66744

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 26

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert Rice Lyons

(a) Residence. No. 346 E Commercial St. 48a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ida A Lyons

6. DATE OF BIRTH (month, day and year) Mar. 13-1879

7. AGE Years 50 Months 2 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Caleb Lyons
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Sarah M. Rice
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs A. R. Rice
(Address) Weiser Idaho

15. Filed June 28, 1929 W. R. Hamilton M.H.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31, 1929, to ..... 19..., that I last saw him alive on May 31, 1929 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Endocarditis,
..... (duration) Since yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) W. R. Hamilton, M. D.
May 31st, 1929 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial 6-3-1929

20. Undertaker L. C. Northam — Address Weiser, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 1 1929

PLACE OF DEATH

County of Washington

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1010

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66745

Local Registrar's No. 27

2. FULL NAME James Hollenroke

(a) Residence. No. 830 E Court St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE Wht

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Francis Hollenroke

6. DATE OF BIRTH (month, day and year) Dec 12-1851

7. AGE Years 77 Months 5 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Thomas Hollenroke

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont

12. MAIDEN NAME OF MOTHER Mary Moore

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant John Hollenroke
(Address) Weiser - Idaho

15. Filed June 26, 1929 W. R. Hamilton Registrar

M. N. M.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1929, to May 28, 1929

that I last saw him alive on May 27, 1929

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows: Cancer of stomach

1 year or more (duration) ~~yrs. mos.~~ ds.

CONTRIBUTORY (Secondary) ~~G. M. Waterhouse~~

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? clinical symptoms

(Signed) G. M. Waterhouse M. D.

May 29, 1929 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

RECEIVED JUL 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66746

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 8

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William George Goss

(a) Residence. No. St. 31
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Verna Goss

6. DATE OF BIRTH (month, day and year) Aug 21

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
30	8	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Mrs W. G. Goss
(Address) Weiser Idaho

15. Filed June 28, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 15 '29, 19..., to May 11, 1929
that I last saw h[illegible] alive on May 11, 1929
and that death occurred, on the date stated above, at 1:30 a. m.
The CAUSE OF DEATH* was as follows:
Tuberculosis Pulmonary

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? T.B. Bacilli in sputum
(Signed) C. E. Garnant, M. D.
5/13/29, 19... (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	5-13 1929
20. Undertaker F. C. Northam	Address Weiser Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

M. N. M.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66747

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
(No. R. F. D. No. I)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 36

2. FULL NAME Richard Johnson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Johnson

6. DATE OF BIRTH (month, day and year) Nov 17

7. AGE Years 70 Months 7 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS
10. NAME OF FATHER Thos H. Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Roup.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mary Johnson
(Address) Weiser Idaho

15. Filed June 26, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929, to June 25, 1929
that I last saw him alive on June 25, 1929
and that death occurred, on the date stated above, at 4.30 m
The CAUSE OF DEATH* was as follows:
Multiple Neuritis
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Cancer of Rectum
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) W. H. Marshall, M. D.
June 26, 1929 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial 6-27-1929

20. Undertaker L. C. Northam — Address Weiser Idaho

RECEIVED JUL 18 1929

66748

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66748

PLACE OF DEATH
County of Clearwater Ida
City of Teakeen Ida
P.O.

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Jarvis Michael Kime
(a) Residence. No. Clearwater Co Idaho St. Resident
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred Many yrs. yrs. mos. ds. How long in U. S., if of foreign birth? X yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Flora B Kime
6. DATE OF BIRTH (month, day and year) Oct 2 - 1842
7. AGE Years 86 Months 7 Days 15 If LESS than 1 day, X hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer & Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) Employed Himself
(c) Name of employer None
9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER George Kime
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Julia Springer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. X Informant Flora B. Kime
(Address)

15. Filed July 10, 1929 B. F. Nesbit Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 10th (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from at times, 1928, to June 10, 1929
that I last saw him alive on June 10th, 1929
and that death occurred, on the date stated above, at 12:10 A m.
The CAUSE OF DEATH* was as follows:
— Old age - complications of
Many yrs (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) None
X (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? X Place of Death
Did an operation precede death? No Date of X
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Russell Truitt M. D.
June 10, 1929 (Address) Southwick Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Southwick Cemetery
Date of Burial June 11 1929
20. Undertaker J. L. Pickard
Address Troy Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

66-749

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66749

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 2161
Primary Registration District No. 28
(No. Lyne Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5387

101a

2. FULL NAME William Bush
(a) Residence. No. 227 N. Johnson St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) April 14 1861
7. AGE Years 68 Months 1 Days 19 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER William Bush
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Anna Bush
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Louis Dugard
(Address) 227 N. Johnson
15. Filed 6/3, 1929 J. W. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 3rd 29 19
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 31, 1929, to June 3rd 1929
that I last saw him alive on June 3rd, 1929
and that death occurred, on the date stated above, at 5 A. m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) age.
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? 227 no. Johnson
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? physical findings
(Signed) J. W. Lyne M. D.
June 3rd, 1929 (Address) Pocatello Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountainview Cemetery
Date of Burial June 5 1929
20. Undertaker H. L. McHam
Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

66750

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66750

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 24
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5600

74a

2. FULL NAME Benjamin Achin
(a) Residence. No. Pocatello Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Exact date unknown

7. AGE 58 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheep man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ~~J. California~~

PARENTS
10. NAME OF FATHER Christopher Achin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) France
12. MAIDEN NAME OF MOTHER Rosalia Oliver
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) France

14. Informant J. J. Achin
(Address) Pocatello Ida

15. Filed 6/20, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1929, to June 9, 1929
that I last saw him alive on June 9, 1929
and that death occurred, on the date stated above, at 2:30 P m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Chronic neflentis
(duration) Sinusal yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Paralysis
(Signed) A. M. Newton M. D.
June 9, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View | Date of Burial June 12 1929

20. Undertaker Schumacher & Beasley | Address City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 24 1929

66752

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66752

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2141
(No. 147 Roosevelt Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 519

2. FULL NAME William O. Stratton

49

(a) Residence. No. 1005 South Third Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Iris Ann Lincoln

6. DATE OF BIRTH (month, day and year) Dec. 31, 1888.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	6	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Joseph Stratton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Laura Griffin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant Mrs. W.O.Stratton
(Address) 1005 So. Third Ave.

15. Filed 7/15, 1929. J.H. Jennings Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 13, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11, 1929, to July 13, 1929, that I last saw h[illegible] alive on July 13, 1929, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
of Heart
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Locomotor Ataxia
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? at Place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) J F Miller M. D.
7/15 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Idaho	July 16 1929

20. Undertaker Arthur W Hall
Address Pocatello

66753

RECEIVED JUL 31 1929

PLACE OF DEATH

County of Teton

City of Driggs

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 77

Primary Registration District No. 9176

(No. ....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66753

Local Registrar's No. 1

171

2. FULL NAME Stillman Buxton

(a) Residence. No. .... St. ....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Louie Van Leuvan

6. DATE OF BIRTH (month, day and year) Nov. 24th 1881

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	7	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Smithfield Utah.

PARENTS

10. NAME OF FATHER John Buxton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Mary A. Pond

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Loyd Buxton
(Address) Driggs, Idaho.

15. Filed 7-13-, 1929 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) - 8 (Day) - 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~—~~, 19~~—~~, to ~~—~~, 19~~—~~
that I last saw h~~—~~ alive on ~~—~~, 19~~—~~
and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Suicide By Cutting Throat with pocket Knife

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? .... Date of ....
Was there an autopsy? ....
What test confirmed diagnosis? Coroners inquest

(Signed) John Emmett Corning M.D.
July 10, 1929 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bates, Idaho	7-11-1929

20. Undertaker .... Address Lewis Kiser Ashton, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

66754

DO NOT WRITE IN THIS SPACE
State File No. 66754

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 54

(No. U. S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harvey B. POWERS

(a) Residence. No. 1302 E. State St., Boise, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. X yrs X mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

1002

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 11-21-1842

7. AGE	Years	Months	Days	If LESS than 1 day,
	86	8	1	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant M. Cornelius
(Address) U. S. Vet. Bureau, Boise, Idaho

15. Filed 7/22, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 19 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9, 19 29, to July 22, 19 29
that I last saw him alive on July 22, 19 29
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endarteritis, right foot

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? xx

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? xx

(Signed) F. C. Smith, Reg. Med. Officer M. D.

7-22-29, 19 (Address) U. S. Veterans' Bure
Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian, Idaho	19

20. Undertaker	Address
W. S. Mateer	Meridian, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1929

66755

DO NOT WRITE IN THIS SPACE

State File No. 66755

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 190

(No. 1612 Denver Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lewis H. Fry.

(a) Residence. No. Bend, Oregon. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Divorced.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Corrilla Fry

6. DATE OF BIRTH (month, day and year) May 14th 1865

7. AGE Years	Months	Days	If LESS than 1 day
64	2	10	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER H. C. Fry.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Susan Conrey.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know.

14. Informant Guy O. Fry.

(Address) Boise, Idaho.

15. Filed 7/27, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 24th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to July 24, 1929
that I last saw him alive on July 23, 1929
and that death occurred, on the date stated above, at 9:00 a.m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Cholecystitis & cholelithiasis (duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical findings

(Signed) Dr. J. M. Dafoe, M. D.

7/24/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello, Idaho	Shipped 7/27/29, 19
20. Undertaker Wm. McBratney.	Address Boise, Ida.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66756

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 178

2. FULL NAME Ezra Elkanah Howard.
(a) Residence. No. ..... St. Pioneerville Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Oct-18-1844
7. AGE: Years 84, Months 8, Days 22. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mining
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Kentucky

PARENTS
10. NAME OF FATHER: James Howard
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Rebecca MacCracken
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14. Informant: Homer E Howard
(Address) Pioneerville Idaho
15. Filed 7/12, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 4, 1929, to July 10, 1929
that I last saw him alive on July 9, 1929
and that death occurred, on the date stated above, at 1 a m.
The CAUSE OF DEATH* was as follows: Rocky Mountain Tick Fever
..... (duration) ..... yrs. ..... mos. 20 ds.
CONTRIBUTORY (Secondary) —
— (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? Pioneerville Id
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) O H Parker, M. D.
July 10, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Edgar Nebraska. Date of Burial: Sept. 15 1929
20. Undertaker: Summers & Krebs Address: Boise Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66757

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 4 04
Local Registrar's No. 177
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nels Andreas Elster

(a) Residence. No. 1402 Denver Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary J. Elster.

6. DATE OF BIRTH (month, day and year) Nov. 24 1863

7. AGE: Years 65 | Months 7 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Guard at Idaho
(b) General nature of industry, business, or establishment in which employed (or employer): State Penetentary
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Norway

PARENTS
10. NAME OF FATHER: Elster
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Emery Olsen
(Address): Placerville Idaho

15. Filed 7/5, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1929 to July 5, 1929
that I last saw him alive on July 5, 1929
and that death occurred, on the date stated above, at 7 30 a m.
The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid
(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of July 3 29
Was there an autopsy? No
What test confirmed diagnosis? Confirmed at operation.

(Signed) Dr. J. J. Brach, M. D.
July 5, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: July 8 1929
20. Undertaker: Sweanners & Kube — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66758

PLACE OF DEATH
County of Ada
City of Boise Idaho
Registration District No.
Primary Registration District No.
Local Registrar's No. 176
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME S.E. Burnham
(a) Residence. No. 902 N 19th St St.
(Usual place of abode)
Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

49

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Bella Burnham

6. DATE OF BIRTH (month, day and year) April 8th 1856

7. AGE	Years	Months	Days	If LESS than 1 day,
73		2	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) La Porte Iowa

PARENTS

10. NAME OF FATHER Ezra. Burnham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Laporte Iowa
12. MAIDEN NAME OF MOTHER Louise Nolon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Laporte Iowa

14. Informant J M Sharp
(Address) 1318 N 13th

15. Filed 7/3, 1929 W. D. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1929, to July 2, 1929
that I last saw h[e] alive on July 2, 1929
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma- cervical glands

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of 1928
Was there an autopsy? No
What test confirmed diagnosis? Yes
(Signed) Louis V. Genoway, M. D.
July 3, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Shipment

19. Place of Burial, Cremation, or Removal: Chehalis, Wash — Date of Burial: July 3 1929
20. Undertaker: Schreiber & McCann — Address: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Farney

RECEIVED AUG 5 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66759

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 175

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Donald Hugh Cook.

(a) Residence. No. Robie Creek. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) August 21st 1927

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	10	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Yoncolla, Oregon.

PARENTS

10. NAME OF FATHER Hugh A. Cook.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Great Falls, Mont.

12. MAIDEN NAME OF MOTHER Bessie Clemons.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn.

14. Informant Hugh A. Cook.
(Address) Robie Creek, Boise.

15. Filed 7/3, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 30th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to June 30, 1929
that I last saw him alive on June 30, 19
and that death occurred, on the date stated above, at 3 P.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Infection Brain abscess
(Nature Unknown)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms and Circumstantial

(Signed) [illegible], M. D.
7/1/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	7/1/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66760

Local Registrar's No. 174

PLACE OF DEATH
County of Ada
City of Boise
Registration District No.
Primary Registration District No.
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William J. Grisham

(a) Residence. No. 611 Grove St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Sallie Grisham

6. DATE OF BIRTH (month, day and year): Apr 26 - 1852

7. AGE: Years 77 | Months 2 | Days 3 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mo.

PARENTS
10. NAME OF FATHER: John Grisham
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn.
12. MAIDEN NAME OF MOTHER: Nancy Wheeler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn.

14. Informant: Edgar E. Grisham
(Address): 506 Washington

15. Filed 7/1, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-28, 1929, to 6-29, 1929
that I last saw him alive on 6-29, 1929
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Apoplexy

(duration) ____ yrs. ____ mos. 1 ds.
CONTRIBUTORY (Secondary): High blood pressure
(duration) 15 yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? His home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P. P. Fisher, M. D.
7-1, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 7-1 1929
20. Undertaker: Schreiber & McCain — Address: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. 1602 N. 7th Street)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66761

Local Registrar's No. 173

2. FULL NAME Hettie Eureka Pointer

(a) Residence. No. 1602 N. 7th Street St.

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel James Pointer

6. DATE OF BIRTH (month, day and year) Dec. 5- 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	67	6	23	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Laramie Donovan County Kansas

PARENTS

10. NAME OF FATHER Samuel Stillwell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Jersey

12. MAIDEN NAME OF MOTHER Susie Powers

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant L. L. Pointer

(Address) 1602 N. 7th Street

15. Filed 7/1, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) — 28 (Day) — 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1929, to June 28, 1929

that I last saw her alive on June 28, 1929

and that death occurred, on the date stated above, at 11:5 A m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs following
Thrombosis Arteriosclerosis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

? (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Calloway-Japlin, M. D.

July 1, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal	Date of Burial
Schreiber & McCann	6/30 1929
Undertaker Burris	Address
Morris Hill Cemetery	Boise

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66762

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 172
(No. St. Luke's Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dorothy Ellen Hamilton
(a) Residence. No. 1103 - 6th St. South St. Nampa, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 28th 1909

7. AGE	Years	Months	Days	If LESS than 1 day,
	19	8	1	hrs, or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work school girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Nampa
(State or country) Idaho

PARENTS

10. NAME OF FATHER Robt T. Hamilton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Jessie Lenant
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penna.

14. Informant Mrs. R. T. Hamilton
(Address) Nampa, Idaho

15. Filed July 1, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-21-, 1929, to 6-29-, 1929
that I last saw her alive on 6-29, 1929
and that death occurred, on the date stated above, at 7:30 P. m.
The CAUSE OF DEATH* was as follows:
Streptococci Bacteraemia.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Secondary Anaemia
(duration) yrs. mos. ds.

18. Where was disease contracted? if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory Cultures
(Signed) O. F. Saunders, M. D.
7-1, 1929 (Address) 319 Eastman Bldg Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn, Nampa	7-2 1929
20. Undertaker	Address
Mrs. Nina M. Talley	Nampa, Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66763

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 58

(No. Ada County Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mathias Rose

(a) Residence. No. 110 Boise, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Rose.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 65			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) W

12. MAIDEN NAME OF MOTHER W

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) W

14. Informant Pearl Allen.

(Address) Boise, Idaho

15. Filed 7/31, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 27th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 27, 1929
that I last saw him alive on July 26, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Oesophagus
(duration) 2 yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
Starvation (duration) yrs. mos. 30 ds.

18. Where was disease contracted if not at place of death? Ada County
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. M. Bratton M. D.
7/29/29, 19 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	7/30/29 19
20. Undertaker	Address
Wm. McBratney.	Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66764

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 57

(No. U. S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Charles E. JENSEN

(a) Residence. No. Idaho Falls, Idaho St. Idaho Falls, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. x yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Belva Winn Jensen

6. DATE OF BIRTH (month, day and year): 2-10-1895

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	5	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: Charles Jensen

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Lettie Christensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: M. Cornelius

(Address) U. S. Vet. Bureau, Boise, Idaho.

15. Filed 7/30, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to July 30, 1929

that I last saw h... im alive on July 30, 1929

and that death occurred, on the date stated above, at 12:15 A. m.

The CAUSE OF DEATH* was as follows:

Acute dilation Heart

(duration) ... yrs. ... mos. 4 hrs.

CONTRIBUTORY (Secondary): Duodenal Ulcer, perforated

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 7-23-29

Was there an autopsy? Yes

What test confirmed diagnosis? Acute peritonitis following ruptured Duodenal ulcer.

(Signed) F. C. Smith, Regional Medical Offr.

7-30-29, 1929 (Address) U.S.Vet. Bureau Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho — Date of Burial: Shipped 7/30/29, 19

20. Undertaker: Wm. McBratney. — Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66765

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 56

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fannie Rebecca Lunstrum

(a) Residence. No. 5 miles S W of Boise St.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Lunstrum

6. DATE OF BIRTH (month, day and year): Oct. 13 1860

7. AGE: Years 68 | Months 9 | Days 9 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS

10. NAME OF FATHER: Charles B. Lee
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Emelia Ann Emerick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New York

14. Informant: Albert Lunstrum
(Address) Boise Idaho Rt # 2

15. Filed 7/24, 1929 W. V. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan., 1929, to July 22, 1929
that I last saw her alive on July 22, 1929
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Chronic myocarditis
Embolism left femoral artery
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) High Blood Pressure ?
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) A. J. Coats, M. D
, 19 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: July 24 1929
20. Undertaker: Summers & Trebs — Address: Boise Idaho

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66766

PLACE OF DEATH
County of Ada.
City of

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 55

(No. New York Canal S.E. of Boise R.R.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Douglas James Ensign. 182

(a) Residence. No. 1107 State, St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write this word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec-14-1906

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
22	6	28.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Tire Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Wayne Electric
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake Utah

PARENTS

10. NAME OF FATHER Samuel L. Ensign
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake Utah
12. MAIDEN NAME OF MOTHER Mary Ann Gibson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salt Lake Utah.

14. Informant Samuel L. ~~Ensign~~ Ensign
(Address) 421-6 Ave Salt Lake Utah

15. Filed 7/22, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 12th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ , 19 , to , 19
~~that I last saw~~ alive on , 19
~~and~~ that death occurred, on the date stated above, at about 7.30 P. m.

The CAUSE OF DEATH* was as follows: Accidental Drowning

No Inquest held.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Thomas Bibby Coroner M. D.
Boise, Ada, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salt Lake Utah	July 23 1929

20. Undertaker Address
Pierce & Tate Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66768

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2904

(No. Perkins Station)

Local Registrar's No. 53

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Howard.

(a) Residence. No. Boise, Idaho. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Julia Howard.

6. DATE OF BIRTH (month, day and year) December 25th 1860

7. AGE Years	Months	Days	If LESS than 1 day, ~~hrs. or~~ min.
68	6	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Construction Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10. NAME OF FATHER Don't Know.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER Knapp.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant Mrs. Jim Howard.

(Address) Boise, Idaho.

15. Filed 7-19, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 9th 1929. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ ~~, to~~ ~~, 19~~

~~that I last saw him alive on~~ ~~, 19~~

~~and that~~ death occurred, on the date stated above, at Abt 12,55 a. m.

The CAUSE OF DEATH* was as follows: Runs over by Railway Engine. Instantly Killed. Probably Suicide.

CONTRIBUTORY (Secondary) No Inquest held. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? — — —

(Signed) C. M. C. Bailey, Coroner, M. D.

7/10/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	7/11/29 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66769

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 51

(No. U. S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arthur VASSAR

(a) Residence. No. Pendleton, Oregon St. Pendleton, Oregon
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. A. J. Vassar

6. DATE OF BIRTH (month, day and year) 5-3-1889

7. AGE	Years	Months	Days	If LESS than 1 day,
	40	2	10	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Truck driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant M. Cornelius
(Address) U. S. Vet. Bureau, Boise, Idaho

15. Filed 7/15, 1929 W. W. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 14, 1928 to July 13, 1929
that I last saw him alive on July 13, 1929,
and that death occurred, on the date stated above, at 7:25 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial, failure and cardiac decompensation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic regurgitation stenosis
Aortitis specific, pulmonary Edema
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? xx

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? xx

(Signed) E. H. Cooper, M. D.
E.H. Cooper, Act. Reg. Med. Officer
(Address) U.S. Vet. Bureau, Boise Idaho
, 19

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pendleton, Oregon	19

20. Undertaker	Address
Folsom Undertaking Parlor	Pendleton, Oreg.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66770

PLACE OF DEATH
County of Ada
City of Meridian

Registration District No. 8
Primary Registration District No. 2004
(No. N.E. of Meridian)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 50

2. FULL NAME Rachel E. Matlock

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 8 - 1860

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	3	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: Peter Price
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tennessee
12. MAIDEN NAME OF MOTHER: Sarah Hagler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Mrs Cora Coles
(Address) Boise R. 2

15. Filed ~~7-10-1929~~ 7-10-29 ~~H. F. Neal~~ W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6. 30, 1929, to 7-9-, 1929
that I last saw her alive on 7-8-, 1929
and that death occurred, on the date stated above, at 12 noon
The CAUSE OF DEATH* was as follows:
Erysipelas
..... (duration) ..... yrs. ..... mos. 6 ds.
CONTRIBUTORY (Secondary) Auto accident injuries
leg - (duration) ..... yrs. ..... mos. 9 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) H F Neal, M. D.
7-10, 1929 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery
Date of Burial: 7-10-1929

20. Undertaker: W. S. Mater
Address: Meridian

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66771

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 49

(No. U. S. Veterans Bureau, Boise, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

51

2. FULL NAME Joe Verant

(a) Residence. No. ..... St. Fallon, Nevada
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ~~1~~ 2 mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~[illegible]~~ Mrs. Joe Verant

6. DATE OF BIRTH (month, day and year) 12-11-1896

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	6	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer xx

9. BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant L. Kromer

(Address) U. S. Veterans Bureau, Boise, Idaho.

15. Filed 7/9, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 7, 1929

that I last saw him alive on July 7, 1929

and that death occurred, on the date stated above, at 4:45 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic, active, all lobes, both lungs.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) xx

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) W. B. Sellers, M. D.

7/7, 1929 (Address) T. B. Hospital Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fallon, Nevada	Shipped 7-9-29 19
20. Undertaker	**Address**
Wm. McBratney	Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66772

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 48
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stella Hiner

(a) Residence. No. 2 miles S W of Boise St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 25-1883

7. AGE: Years 45 | Months 10 | Days 12 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: James A Sizemore
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Nancy J Hancock
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Ray Hiner.
(Address) Boise Idaho

15. Filed 7/8, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to July 6, 1929
that I last saw h[illegible] alive on July 6, 1929
and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H W Hill D C, M. D.
July 8, 1929. (Address) 330 Boma

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: July 9 1929
20. Undertaker: Summers & Hubbs — Address: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66773

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 47
(No. Ustick, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marshall S. Sevy.

(a) Residence. No. Ustick, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ellen Sevy.

6. DATE OF BIRTH (month, day and year) Aug. 5th 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	10	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER John Sevy.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Mary Robley.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Mrs. Ellen Sevy.
(Address) Ustick, Idaho.

15. Filed 7/1, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ ~~to~~ ~~, 19~~
~~that I last saw him alive on~~ ~~, 19~~
~~and that~~ death occurred, on the date stated above, at 6:50 P.M.

The *CAUSE OF DEATH* was as follows:

Natural causes. Had stroke of paralysis June 27th 1929, never regaining consciousness until he died July 1st 1929. No Doctor was in attendance during his illness. Did not believe in Doctors. No inquest held.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Residence Ustick, Ida
Did an operation precede death? No. Date of XXX
Was there an autopsy? No.
What test confirmed diagnosis? None.

(Signed) Wm. McBratney, Coroner, M. D.
7/1/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverside Cemetery. Near Lake Lowell.
Date of Burial: 7/2/29 19

20. Undertaker: Wm. McBratney.
Address: Boise, Idaho.

RECEIVED AUG 5 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66774

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 195

(No. St Lukes Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George F. Kinnery

(a) Residence. No. Pacific Hotel 9th & Ida St.
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

19

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jane Kinnery

6. DATE OF BIRTH (month, day and year): June 18 - 1844

7. AGE: Years 85, Months 1, Days 11. If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Court Officer
(b) General nature of industry, business, or establishment in which employed (or employer): Bailiff in Ida.
(c) Name of employer: Supreme Court

9. BIRTHPLACE (city or town) (State or country): Tennessee

PARENTS

10. NAME OF FATHER: John Kinnery

11. BIRTHPLACE OF FATHER (city or town) (State or Country): No. Carolina

12. MAIDEN NAME OF MOTHER: Carr

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): No Record

14. Informant: W. H. Kinnery
(Address) 220 N 10 St Boise

15. Filed 7/31, 1929. W. H. Rhodes, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29½ (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29½, 1929, to July 29½, 1929 that I last saw him alive on July 29½, 1929 and that death occurred, on the date stated above, at 4:45 P.m.

The CAUSE OF DEATH* was as follows: Angina pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): High blood pressure -

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

July 31, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Aug 1 1929

20. Undertaker: Schreiber & McCann — Address: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

PLACE OF DEATH

County of Ada

City of Boise

TE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. 210 S 10 St) 48 B

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66775

Local Registrar's No. 194

2. FULL NAME Edna May Beer

(a) Residence. No. Idaho Falls Idaho St. Idaho Falls

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 11-1906

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	4	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10. NAME OF FATHER Samuel Beer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Jennie Fox

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Texas

14. Informant Mrs. Conway Myrtle Wright

(Address) 623 E. 1st Idaho Falls Ida

15. Filed 7/31, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/29, 1929, to 7/30, 1929

that I last saw her alive on 7/30, 1929

and that death occurred, on the date stated above, at 10 15 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Streptotoxemia

(duration) yrs. 7 mos. ds.

18. Where was disease contracted if not at place of death? Idaho Falls

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) F. H. Plunkston, M. D.

7/31, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	Aug 2 1929
20. Undertaker	Address
Summers & Trebo	Boise Ida

Stewart.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66776

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1094
Local Registrar's No. 193
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alice Elizabeth Worstell

(a) Residence. No. 114 E. Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Laurence E Worstell

6. DATE OF BIRTH (month, day and year) Dec 1-1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	7	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS
10. NAME OF FATHER George Harkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Cenenoon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant L E Worstell
(Address) 114 E Idaho st Boise Idaho

15. Filed 7/31, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1929 to July 29, 1929
that I last saw h alive on July 29, 1929
and that death occurred, on the date stated above, at 830 P m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
With Uraemia
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) James K Stewart, M. D.
July 30, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	Aug 1 1929
20. Undertaker	Address
Summers & Krebs	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

1-8-1929

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66777

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 192
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marion Francis Turner

(a) Residence. No. 1224 E. Jefferson St.
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 28-1914

7. AGE: Years 15 | Months 1 | Days 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise Idaho

PARENTS

10. NAME OF FATHER: Lewis E Turner
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Calif.
12. MAIDEN NAME OF MOTHER: Mary Candle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Lewis E Turner
(Address) 1224 E Jefferson St Boise Ida

15. Filed 7/29, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-8-, 1929, to 7-28-, 1929
that I last saw him alive on 7-28-, 1929
and that death occurred, on the date stated above, at 6:30 P m.
The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical and Laboratory
(Signed) O. F. Swindell, M. D.
7-29, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: July 30 1929
20. Undertaker: Summers & Trefs — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 5 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66778

County of Ada.
City of Boise.
Registration District No.
Primary Registration District No.
Local Registrar's No. 191

(No. Empress Hotel, 7th and Main Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME August Johnson.

(a) Residence. No. Sheaville, Oregon. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Christina Johnson.

6. DATE OF BIRTH (month, day and year) August 14th 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	II	II	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Stockman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boda Wermland, Sweden.

PARENTS

10. NAME OF FATHER John Nelson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden.

12. MAIDEN NAME OF MOTHER Martha Jones.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden.

14. Informant Nels Johnson.
(Address) Sheaville, Oregon.

15. Filed 7/29, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 24th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ ~~to~~ ~~, 19~~ ~~that I last saw him alive on~~ ~~, 19~~ ~~and that~~ death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Found Dead. Probably Cerebral Hemorrhage or Apoplexy.

Natural (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) No Inquest held. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No* Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm. McBratney Coroner, M. D.

7-29-29. 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	7/29/29 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66779

PLACE OF DEATH
County of Ada
City of Boise
Registration District No.
Primary Registration District No.
Local Registrar's No. 189

(No. St Lukes Hospital, 14-B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bessie Ordella Burns.
(a) Residence. No. 4 Miles N. W of Eagle Eagle Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Virgil Burns,

6. DATE OF BIRTH (month, day and year): July 31-1896

7. AGE: Years 32 | Months 11 | Days 24 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Cottage Grove Ore

PARENTS
10. NAME OF FATHER: Samuel S. Tabor.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Washington
12. MAIDEN NAME OF MOTHER: Flora Thomas
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Washington

14. Informant: Virgil Burns
(Address) Eagle Idaho. R.D. #1

15. Filed 7/27, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to July 25, 1929
that I last saw her alive on July 24 11:30 a.m., 1929
and that death occurred, on the date stated above, at 12:10 a.m.

The CAUSE OF DEATH* was as follows:
Nephritis complicating pregnancy.
Induced labor vaginal caesarean delivery.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Eclampsia 24 hrs.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of July 24
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. M. Howerton, M. D.
July 25, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Star Cemetery — Date of Burial: July 28 1929
20. Undertaker: Summers & Kuhn — Address: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66780

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No.) 205 a
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 188

2. FULL NAME Mary Donley
(a) Residence. No. 1202 N 16 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Feb 20 1853
7. AGE: Years 76, Months 5, Days 2. If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Pittsburg Pa

PARENTS
10. NAME OF FATHER: George McPherson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown
12. MAIDEN NAME OF MOTHER: Louise Holstead
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn

14. Informant: Mrs Jessie Bedal
(Address) 1202 N. 16 st Boise Idaho
15. Filed 7/23, 19 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 24th, 1929, to July 22, 1929
that I last saw her alive on July 21st, 1929
and that death occurred, on the date stated above, at 7.50 P m.
The CAUSE OF DEATH* was as follows:
Dilatation of lower end of Esophagus
Primating passage of food into stomach
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Extreme kyphosis in lower dorsal region (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? autopsy
(Signed) J. M. Taylor, M. D.
June 23, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: July 24 1929
20. Undertaker: Summers & Krebs
Address: Boise Idaho

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66781

Local Registrar's No. 187

PLACE OF DEATH

County of Ada

City of Boise

Registration District No.

Primary Registration District No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME JOHNSON, RICHARD HARVEY

(a) Residence. No. #521 Idaho Street St.
(Usual place of abode)
Length of residence in city or town where death occurred. 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~WIFE of~~ Catharine M. Johnson

6. DATE OF BIRTH (month, day and year) July 19-1870

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	11	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Silver City, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Richard Z. Johnson

11. BIRTHPLACE OF FATHER (city or town) Akron
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Kathrina Broeg

13. BIRTHPLACE OF MOTHER (city or town) Lindau am
(State or Country) Bodensee, Bavaria, Germany.

14. Informant Carey H. Nixon
(Address) 112 North Sixth St. Boise, Ida.

15. Filed 7/16, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 14th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1928, to July 14th, 1929, that I last saw h alive on July 12th, 1929, and that death occurred, on the date stated above, at 10:25 a m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver
attended from July 2 to July 14th by Dr. L. F. West. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Large Tumor of Liver

(Signed) Lawrence Stewart, M. D.
7/16, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Elks Rest, Morris Hill Cemetery, Boise, Idaho — Date of Burial July 16 1929

20. Undertaker Schreiber & McCANN — Address Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STA AHO
DEPARTMENT O BLIC WELFARE
BUREAU OF VIT STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66782

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 186

2. FULL NAME Carrie Ellen Halveston

(a) Residence. No. 1121 Jeffersonst St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov.-18-1863

7. AGE Years 65 Months 7 Days 26 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER Nathan McCummins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Ellen F. Thorp
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Conn

14. Informant Chester N Halveston
(Address) % First Nat Bank Bellingham Wash

15. Filed 7/15, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to July 13, 1929
that I last saw her alive on July 10, 1929
and that death occurred, on the date stated above, at 11:30 p.m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis with decompensation.
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) N. A. Koelsch, M. D.
July 16, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: July 18 1929

20. Undertaker: Summers & Krebs
Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66783

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 185
(No. 61 E. Alphonsus)
(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Ernest Hormann

(a) Residence. No. ..... St. ..... Spokane Wash
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edna Hormann

6. DATE OF BIRTH (month, day and year) Jan 19 - 1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	5	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colorado

PARENTS

10. NAME OF FATHER Charles Hormann
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Fredrica Spencer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Sarah Hormann
(Address) Spokane, Wash

15. Filed 7/14 1929 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28, 1929, to July 11, 1929
that I last saw h[illegible]live on July 10, 1929
and that death occurred, on the date stated above, at A m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms
(Signed) W L Treager, M. D.
July 12 1929 (Address) 513 East 15th

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetry	7-12 1929
20. Undertaker	Address
Schreiber McCann	Boise Ida

Forney

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66784

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No.

Primary Registration District No.

Local Registrar's No. 184

(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Ruth A. King.

(a) Residence. No. 1603 N. 19th St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

126

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: E. T. King.

6. DATE OF BIRTH (month, day and year): March 27th 1858

7. AGE: 70 Years | Months: 3 | Days: 14 | If LESS than 1 day, ~~hrs. or~~ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10. NAME OF FATHER: Owen Miller.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Don't Know.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Violet Reed.
(Address) Boise, Idaho.

15. Filed 7/12, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 11th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1929, to July 11, 1929 that I last saw her alive on July 11, 1929 and that death occurred, on the date stated above, at 4:20 A.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 7-1-29

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) Dutomey, M. D.

7/11/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: 7/13/29 19

20. Undertaker: Wm. McBratney. | Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66785

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 183

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Mrs. Rebbeca Mildred Johnson.

(a) Residence. No. Eagle, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Percy Johnson

6. DATE OF BIRTH (month, day and year) October 6th 1909

7. AGE Years	Months	Days	If LESS than 1 day, ... min.
19	9	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Eagle, Idaho.

PARENTS

10. NAME OF FATHER Louis F. Graham.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boise, Idaho.

12. MAIDEN NAME OF MOTHER Susan Mannel.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Percy Johnson.
(Address) Eagle, Idaho.

15. Filed 7/11, 1929 W. D. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 9th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to July 9, 1929
that I last saw her alive on July 9, 1929
and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
of 9 years duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Scarlet fever at age 11 years

(duration) 8 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. J. Coats, M. D.

7/10/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	7/12/29 19

20. Undertaker Wm. McBratney. Address Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

For RECEIVED AUG 5 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66786

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 182
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME Adele Compton.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) July 9th 1929

7. AGE Years	Months	Days	If LESS than 1 day,
0	0	0	7 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Michael A. Compton.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boise, Idaho.
12. MAIDEN NAME OF MOTHER Marian E. Tippett.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Butte, Mont.

14. Informant M. A. Compton.
(Address) Boise, Idaho.

15. Filed 7/10, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 9th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ✓, 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at 9:30 PM m.
The CAUSE OF DEATH* was as follows:
Congenital heart disease,
Patent foramen ovale

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY ✓
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) A. J. Coats, M. D.
7/10/29, 19... (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	7/10/29 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66787

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 181

(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bernice Messick.

(a) Residence. No. Children's Home, Boise. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. I mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) January 28th 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
I	5	II	----------

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Ida.

PARENTS

10. NAME OF FATHER B. H. Messick.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Mrs. Carse, Supt.

(Address) Children's Home, Boise, Ida.

15. Filed 7/10, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 9th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1929, to July 9, 1929
that I last saw her alive on July 9, 1929
and that death occurred, on the date stated above, at 2 PM m.
The CAUSE OF DEATH* was as follows: Epidemic Cerebro spinal Meningitis

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Idaho Falls, Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) Chas. R. Lowe, M. D.
7/10/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	7/11/29 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Stone & Morris

DO NOT WRITE IN THIS SPACE
State File No. 66788

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 180

(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ora Travis Barnes

(a) Residence. No. 1113 Boise Avenue St.
(Usual place of abode)
Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

R

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Allie May Barnes

6. DATE OF BIRTH (month, day and year) Mar. 3. 1892.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	4	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Davis Packing Co.

9. BIRTHPLACE (city or town) (State or country) Oklahoma

PARENTS

10. NAME OF FATHER James E. Barnes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Texas
12. MAIDEN NAME OF MOTHER Mary Graves
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Mrs. O. T. Barnes
(Address) R #4 Boise Idaho.

15. Filed 7/9, 1929 W. T. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1929, to July 8, 1929
that I last saw h-- alive on July 8, 1929
and that death occurred, on the date stated above, at 11-25 P m.
The CAUSE OF DEATH* was as follows:
Basal meningitis

(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Acute mastoid infection
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of July 6, 29
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Harold W Stone M. D.
7/10, 1929 (Address) Eastman Bldg. Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	July, 11 1929
20. Undertaker	Address
Summers & Trebs	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66789

PLACE OF DEATH
County of Ada
City of Boise

Registration District No.
Primary Registration District No.
(No. St. Luke's)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 179

2. FULL NAME Thomas Ireton

(a) Residence. No. Meridian, Ida St. 100a R
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 4 - 1841

7. AGE Years 88 Months Days 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Ted Ireton
(Address) Portland Oregon

15. Filed 7/9, 1929 W. A. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 7, 1929
that I last saw him alive on July 6, 1929
and that death occurred, on the date stated above, at 10 - a - m.
The CAUSE OF DEATH* was as follows:
Bronchial pneumonia following operation for abcess of elbow.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of July 2-29.
Was there an autopsy? no.
What test confirmed diagnosis? operation
(Signed) N. F. [illegible], M. D.
7 - 8, 1929 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Meridian Cemetery Date of Burial July 11 1929

20. Undertaker W. S. [illegible] Meridian Id Address

R RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66790

PLACE OF DEATH
County Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 261
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5594

2. FULL NAME Ocean Milliken
(a) Residence. No. 3 miles N of city St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 11 1913

7. AGE Years 16 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS
10. NAME OF FATHER George H. Milliken
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Grace Wright
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant G. H. Milliken
(Address) Pocatello Idaho

15. Filed 6/10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 7 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7, 1929, to June 6, 1929
that I last saw her alive on June 6th, 1929
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Streptococcic Septicemia
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D C Ray, M. D.
6-8, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt Moriah Cem Date of Burial 6/9/29

20. Undertaker H. L. McHan Address Pocatello Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 28

DO NOT WRITE IN THIS SPACE

State File No. 66791

Registration District No. 2161

Primary Registration District No.

Local Registrar's No. 5593

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

(No. GENERAL HOSPITAL)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ELIZABETH REYNOLDS DUFFIN

(a) Residence. No. 234 - N - GARFIELD AVE. St. 107

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) AUG. 21, 1883

7. AGE	Years	Months	Days	If LESS than 1 day,
	45	9	14	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work HOUSEWIFE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) UTAH

PARENTS

10. NAME OF FATHER RUPERT BROWN

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ENGLAND

12. MAIDEN NAME OF MOTHER ELEANOR KILLUP

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ENGLAND

14. Informant MRS. NELLIE WOLF

(Address) BINGHAM, UTAH.

15. Filed 6/7, 1929 M Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JUNE 5, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20, 1929, to June 5, 1929
that I last saw her alive on June 5, 1929
and that death occurred, on the date stated above, at 11:40 a m.

The CAUSE OF DEATH* was as follows:

Collapsed trachea
causing respiratory failure
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Colloid adenoma
goiter
(duration) 3 ? yrs. mos. ds.

18. Where was disease contracted if not at place of death? Pocatello

Did an operation precede death? Yes Date of 5/20/29

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) H C Dunn, M. D.

6/7, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: MOUNTAIN VIEW CEMETERY — Date of Burial: JUNE 8, 1929

20. Undertaker: ARTHUR W. HALL — Address: POCATELLO

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66792

Registration District No. 78
Primary Registration District No. 24
Local Registrar's No. 5592

PLACE OF DEATH
County of BANNOCK
City of ARIMO
(No. R. R. CROSSING ARIMO, IDA.
(If death occurred in a hospital or institution, give its name instead of street and number.)

189C

2. FULL NAME RAYMOND M. SORENSEN

(a) Residence. No. ARIMO, IDAHO. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) MAY, 19, 1923

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
6	0	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home. NONE
(b) General nature of industry, business, or establishment in which employed (or employer): CHILD
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) MARSH CENTER IDAHO.

PARENTS

10. NAME OF FATHER WILFORD H. SORENSEN
11. BIRTHPLACE OF FATHER (city or town) (State or Country) MENDON, UTAH
12. MAIDEN NAME OF MOTHER GENAVE MELDRUM
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) WEST JORDAN, UTAH.

14. Informant MRS. W. H. SORENSEN
(Address) ARIMO, IDAHO.

15. Filed 6/7, 1929. J. H. Young. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JUNE 5, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Broken neck fracture of skull
hit by freight train while
riding on auto truck
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) (accidental)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Arthur W. Hall. M.D.
6/7, 1929 (Address) Coroner Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
ARIMO, IDAHO.	JUNE 9, 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66793

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 216
(No. GENERAL HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5591

128

2. FULL NAME ELLA BRADLEY BOYD
(a) Residence. No. 528-N-ARTHUR St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): AUG 28, 1879

7. AGE: Years 49, Months 9, Days 7. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: HOUSEWIFE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): UTAH

PARENTS

10. NAME OF FATHER: GEORGE EATOUGH
11. BIRTHPLACE OF FATHER (city or town) (State or Country): FRANCE
12. MAIDEN NAME OF MOTHER: SARAH ALLITON
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ENGLAND

14. Informant: MRS DAVID Bradly
(Address) 528-N-ARTHUR

15. Filed 6/7, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: JUNE (Month) 5 (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1929, to June 5, 1929
that I last saw her alive on June 5, 1929
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Acute Nephritis [illegible] Uremia
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Amulation of leg from gangrene of Thrombosis for Operation (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? Yes Date of 2/20/29
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) O. F. Call, M. D.
6/7, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: GOSHEN, IDA. Date of Burial: JUNE 8, 1929

20. Undertaker: ARTHUR W. HALL Address: POCATELLO

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66794

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 216
(No. GENERAL HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5590

188 C

2. FULL NAME WILFORD KENNETH PARRIS

(a) Residence. No. ARIMO, IDAHO. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) DEC. 6 1919

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	9	5	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work AT SCHOOL
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ARIMO, IDA.

PARENTS

10. NAME OF FATHER WILFORD PARRIS
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ARIMO, IDAHO.
12. MAIDEN NAME OF MOTHER PEARL EGAN
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) RICHMOND, UTAH

14. Informant MRS. WILFORD PARRIS
(Address) ARIMO, IDAHO.

15. Filed 6/7, 1929. J. H. Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JUNE 5, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/5—, 1929, to 6/5—, 1929
that I last saw h[illegible] alive on 6/5—, 1929
and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows: Crushed Skull — Fractured left humerus Truck (auto) struck by Freight train R.R. Crossing at Arimo — (duration) ____ yrs. ____ mos. 1/2 ds.

CONTRIBUTORY (Secondary) ____ (duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? NO Date of —
Was there an autopsy? NO
What test confirmed diagnosis? Clinical

(Signed) J. H. Young, M. D.
6/7, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
ARIMO, IDAHO.	JUNE 9, 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66795

PLACE OF DEATH
County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 216
(No. R. R. CROSSING ARIMO, IDA.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 5589

2. FULL NAME WILMA CAROLINE SORENSEN

(a) Residence. No. ARIMO, IDAHO. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

148 e

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) MAR. 6, 1921

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	8	3	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work AT SCHOOL
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) MARSH CENTER IDAHO.

PARENTS

10. NAME OF FATHER WILFORD H. SORENSEN
11. BIRTHPLACE OF FATHER (city or town) (State or Country) MENDON, UTAH.
12. MAIDEN NAME OF MOTHER GENAVE MELDRUM
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) WEST JORDAN, UTAH.

14. Informant MRS. W. H. SORENSEN
(Address) ARIMO, IDAHO.

15. Filed 6/7, 1929. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JUNE (Month) 5, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Double compound fracture of skull. Hit by freight car(s) Strain while riding in truck at arimo crossing.
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) (accidental)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Arthur W Hall Coroner, M. D.
6/7, 1929 (Address) Pocatello.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
ARIMO, IDAHO.	JUNE 9, 1929
20. Undertaker	**Address**
ARTHUR W. HALL	POCATELLO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66796

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 214
(No. Lynn Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5588

2. FULL NAME Harrold Alven Gray.
(a) Residence. No. 320 W Fremont St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

126

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 22 - 1913

7. AGE: 15 Years, 6 Months, 13 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Oklahoma

PARENTS
10. NAME OF FATHER: F H Gray.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kansas.
12. MAIDEN NAME OF MOTHER: Scott
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: F H Gray.
(Address) Pocatello

15. Filed 6/6, 1929 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26, 1929, to June 4, 1929
that I last saw him alive on June 4, 1929
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:
General Peritonitis
(duration) — yrs. — mos. 8 ds.
CONTRIBUTORY (Secondary) Ruptured appendix
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? Pocatello. Ida
Did an operation precede death? yes Date of May 26
Was there an autopsy? no.
What test confirmed diagnosis? operation
(Signed) J. H. Lynn, M. D.
6-5-, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mt View
Date of Burial: 6-5 1929

20. Undertaker: Schumacher & Beasley
Address: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66797

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 214
Local Registrar's No. 5586
(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ida May Lish

(a) Residence. No. 522 - No 9th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Archie A Lish

6. DATE OF BIRTH (month, day and year) Sept 21 - 1894

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	8	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mc Cammon Idaho

PARENTS

10. NAME OF FATHER Charles A Pomeroy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Anna May Norton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Logan Utah

14. Informant Archie A Lish
(Address) 522 - No 9th City

15. Filed 6/5, 1929 J. H. Morris Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 5 - 1929
that I last saw her alive on June 5 - 1929
and that death occurred, on the date stated above, at 10 15 a m.
The CAUSE OF DEATH* was as follows: Cerebro-spinal Meningitis
Epidemic form
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Pyaemia
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical and Laboratory
(Signed) W. F. Howard M. D.
June 5, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mc Cammon Idaho	June 6 1929

20. Undertaker Arthur W Hall — Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M-1-19

RECEIVED JUL 20 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66798

Local Registrar's No. 5585

1. PLACE OF DEATH

County of Bannock Registration District No. 28

City of McCammon Primary Registration District No. 2461

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Iverson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6. DATE OF BIRTH: June (Month) 15 (Day) 1840 (Year)

7. AGE: 88 Yrs. 11 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) At home

9. BIRTHPLACE (State or Country) Stonna, Sweden

10. NAME OF Father Unknown

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Tuma

(Address) McCammon Idaho

15. Filed 6/3 1929 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13th 1929. to June 2— 1929

that I last saw her alive on June 2— 1929,

and that death occurred on the date stated above, at 3 p. M.

The CAUSE OF DEATH* was as follows:

Cardio-renal disease

(Duration) ..... yrs. 6 mos. ..... ds.

Contributory (Secondary) age-arterio-sclerosis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Dr. W. Lynn M. D.

June 3 1929 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Smithfield, Utah DATE OF BURIAL 1929

20. UNDERTAKER C. P. Lundgren ADDRESS Logan, Utah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Raaff.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66799

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2461
Local Registrar's No. 5584
(No.) Pocatello General Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME J. R. Jefferies
(a) Residence. No. 503 N. Main St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 18, 1874

7. AGE 54 Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work News agent
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouria

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Mary Jefferies
(Address) Pocatello Idaho

15. Filed 6/3, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1929, to ~~May~~ June 1, 1929
that I last saw him alive on May 31, 1929
and that death occurred, on the date stated above, at 1 a m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. J. Raaf, M. D.
June 1, 1929 (Address) Pocatello Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountainview Cem. Date of Burial June 2 1929

20. Undertaker H. L. McNair Address Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66800

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 241
(No. LYNN BROS. HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5583

2. FULL NAME JULIA ARRIZABALAGA

(a) Residence. No. 140 - N - 1ST AVE. St. 31
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE
4. COLOR OR RACE SPANISH WHITE
5. Single, Married, Widowed, or Divorced (write the word) MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ED ARRIZABALAGA

6. DATE OF BIRTH (month, day and year) APRIL 5, 1902

7. AGE Years 27 Months 1 Days 25 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work HOUSEWIFE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) SPAIN

PARENTS

10. NAME OF FATHER ANTONIO ARRILLAGA
11. BIRTHPLACE OF FATHER (city or town) (State or Country) SPAIN
12. MAIDEN NAME OF MOTHER PETRA UNAMUNU
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) SPAIN

14. Informant ED ARRIZABALAGA
(Address) POCATELLO, IDAHO.

15. Filed 6/3, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MAY (Month) 30, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1928, to May 30th, 1929
that I last saw her alive on May 30th, 1929
and that death occurred, on the date stated above, at 1.30 A. m.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Don't know
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical findings
(Signed) J. W. Lynn M. D.
June 2nd, 1929 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal MOUNTAIN VIEW CEMETERY
Date of Burial 6-3-1929

20. Undertaker ARTHUR W. HALL
Address POCATELLO

Original

RECEIVED JUL 20 1929

STATE of Idaho
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66801

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 216
Primary Registration District No. 38
(No.) Local Registrar's No. 558
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Kumpton

(a) Residence. No. 436 S. Hayes St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma

6. DATE OF BIRTH (month, day and year) Feb 16

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	3	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Contractor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER George Kumpton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York N. Y.
12. MAIDEN NAME OF MOTHER Emma Kumpton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vermont

14. Informant Mrs D.A. Daubner
(Address) Vancouver B. C.

15. Filed 6/3, 1929 J.H. Toomey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to June 2, 1929
that I last saw him alive on June 1, 1929
and that death occurred, on the date stated above, at 2 p.m.
The CAUSE OF DEATH* was as follows:
Mountain Tick Fever
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C.E. Loomis M. D.
6/3, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountainview Cem. Date of Burial: June 4 1929
20. Undertaker: H.L. McClain Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE HO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 28

DO NOT WRITE IN THIS SPACE
State File No. 66802

PLACE RECEIVED JUL 20 1929

County of Bannock
City of Pocatello
Registration District No. 216
Primary Registration District No.
(No. Pocatello Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 5581

44

2. FULL NAME Bessie E Brookhart

(a) Residence. No. 843 N Arthur St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
~~(or)~~ WIFE of N S Brookhart

6. DATE OF BIRTH (month, day and year) 10-2-1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	7	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa - Selma

PARENTS

10. NAME OF FATHER W F Brewster
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Toledo, Ohio
12. MAIDEN NAME OF MOTHER Elvina J. Camblin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dayton Ohio

14. Informant Ray Brookhart
(Address) Pocatello, Idaho

15. Filed 5/31, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-1, 1929, to 5-28, 1929
that I last saw her alive on 5-28, 1929
and that death occurred, on the date stated above, at 11 A. m.
The CAUSE OF DEATH* was as follows:
Shock following surgical operation
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Carcinoma stomach and colon
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 5/28/29
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature], M. D.
5/30, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt Moriah Cemetery	5-30 1929
20. Undertaker	Address
Schumacher & Beasley	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66804

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5579

161a

2. FULL NAME Glenn Roland Duffin

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): S

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) May 16 - 1929

7. AGE: Years — Months — Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello Idaho

PARENTS

10. NAME OF FATHER: Roland H Duffin
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Ella Phillips
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Roland H. Duffin
(Address): Aberdeen Idaho

15. Filed 5/27, 1929 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1929, to May 25, 1929
that I last saw him alive on May 25, 1929
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows:

Premature twins (7 mo)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
5-27, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Aberdeen Idaho
Date of Burial: May 27 1929

20. Undertaker: Arthur W Hall
Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66805

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 2
Primary Registration District No. 216
Local Registrar's No. 5578
(No. 152 S. 1st E. Rear)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME Eddie Bindo

(a) Residence. No. Rear 152 S. 1st St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Negro	—

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) May 5-1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	17		17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER Eddie Bindo
11. BIRTHPLACE OF FATHER (city or town) unknown
(State or Country)
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) unknown
(State or Country)

14. Informant Eddie Bindo
(Address) Pocatello Idaho

15. Filed 5/24 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5/23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/10, 1929, to 5/23, 1929
that I last saw h[illegible] alive on 5/22/29, 1929
and that death occurred, on the date stated above at 5 P. m.
The CAUSE OF DEATH* was as follows:

unknown

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature] M. D.
5/24, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View	May 24 1929
20. Undertaker	Address
Schumacher & Hensley	City

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66806

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. RANCH NORTH OF CITY)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5577

40

2. FULL NAME SARAH ALEEN BELL

(a) Residence. No. RANCH NORTH OF CITY St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) NOV. 8, 1918

7. AGE	Years	Months	Days	If LESS than 1 day,
	10	6	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work AT SCHOOL
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) POCATELLO,
(State or country)

PARENTS

10. NAME OF FATHER JOHN G. BELL

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) SWEDEN

12. MAIDEN NAME OF MOTHER EMMA INGELSTROM

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) BASALT, IDA.

14. Informant JOHN G. BELL
(Address) POCATELLO IDAHO.

15. Filed 3/24, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MAY (Month) 24, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1927, to May 24, 1929
that I last saw h[illegible] alive on May 23, 1929
and that death occurred, on the date stated above, at 5:30 a.m.
The CAUSE OF DEATH* was as follows:
mitral regurgitation
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D C Roy, M. D.
3-24, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MONNTAIN VIEW CEMETERY	MAY 26 1929

20. Undertaker ARTHUR W. HALL Address POCATELLO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66807

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. GENERAL HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5576

128

2. FULL NAME MARIAN MAUD WINDSOR

(a) Residence. No. 1040 - N - GRANT St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: FRANCIS J. WINDSOR

6. DATE OF BIRTH (month, day and year): SEPT. 20, 1878

7. AGE: Years 50, Months 8, Days 2. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: HOUSEWIFE
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): ENGLAND

PARENTS

10. NAME OF FATHER: THOMAS SEXTY
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ENGLAND
12. MAIDEN NAME OF MOTHER: ESTHER PERRINS
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ENGLAND

14. Informant: FRANCIS J. WINDSOR
(Address) 1040 - N - GRANT

15. Filed 9/24, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: MAY (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1929, to May 22, 1929
that I last saw her alive on May 22, 1929
and that death occurred, on the date stated above, at 1:20 a.m.
The CAUSE OF DEATH* was as follows:
Acute Parenchymatous Nephritis
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Cholecystectomy & appendectomy (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At hospital
Did an operation precede death? Yes Date of May 18, 1929
Was there an autopsy? No
What test confirmed diagnosis? Laboratory of Urine
(Signed) O. Hall M. D.
5/24, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: MOUNTAIN VIEW CEM. Date of Burial: MAY 24, 1929

20. Undertaker: ARTHUR W. HALL Address: POCATELLO,

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66808

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 21 61
(No. 1433 - So. 4TH AVE.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5575

167

2. FULL NAME JOHN FIFE MARLEY

(a) Residence. No. 1433 - SOUTH 4TH AVE. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) MAY. 17, 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	0	1	hrs. / min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work INFANT
(b) General nature of industry, business, or establishment in which employed (or employer) NONE
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) POCATELLO,

PARENTS

10. NAME OF FATHER J. E. MARLEY
11. BIRTHPLACE OF FATHER (city or town) (State or Country) IDAHO
12. MAIDEN NAME OF MOTHER LAVERN FIFE
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UTAH

14. Informant J. E. MARLEY
(Address) 1433 - So. 4TH POCA. IDA.

15. Filed 5/24, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MAY. (Month) 17, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 19__, to May 17, 1929
that I last saw h[illegible] alive on May 17, 1929
and that death occurred, on the date stated above, at 11 40 p.m.
The CAUSE OF DEATH* was as follows:
Atelectasis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Short cord
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D. C. Ray, M. D.
5-18, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW CEMETERY	MAY, 17 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66809

PLACE OF DEATH

County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. REAR OF 207 - So. 3RD AVE.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5574

2. FULL NAME ALBERT E. CROFTS

(a) Residence. No. REAR 207 - So - THIRD St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	WIDOWED

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of LORENA HANSEN

6. DATE OF BIRTH (month, day and year) JULY 10, 1877

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	10	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work LABORER
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) UTAH

PARENTS

10. NAME OF FATHER JOHN CROFTS
11. BIRTHPLACE OF FATHER (city or town) (State or Country) WALES
12. MAIDEN NAME OF MOTHER EMMA CROFTS
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ENGLAND

14. Informant EARL CROFTS
(Address) BRIGHAM CITY UTAH

15. Filed 5/24, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MAY 22, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
5-22, 1929, to 5-22, 1929
that I last saw h[illegible] alive on 5-22, 1929
and that death occurred, on the date stated above, at 5 O. m.
The CAUSE OF DEATH* was as follows:
Coronary thrombosis

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Chronic alcoholism?
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

(Signed) [signature] M. D.
5/24, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
BASALT, IDAHO.	MAY 25, 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66810

Local Registrar's No. 5573

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No.) 118 B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Helen Wiebe

(a) Residence. No. St. Anthony Hospital St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 11

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	5	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER H. H. Friesen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia

12. MAIDEN NAME OF MOTHER Schmidt

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant Bernhard Wiebe
(Address) Aberdeen Ida.

15. Filed May 24 19 29 W. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 24 1929
that I last saw her alive on May 24 1929
and that death occurred, on the date stated above, at 8:30 m.
The CAUSE OF DEATH* was as follows:
Intestinal obstruction

(duration) 5 yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Toxemia and exhaustion
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? Aberdeen Idaho
Did an operation precede death? Yes Date of 5/21/29
Was there an autopsy? No
What test confirmed diagnosis? Clinical Symptoms Operation
(Signed) W. F. Hazentil M. D.
5-24, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Aberdeen, Idaho	May 24 1929

20. Undertaker McHandrdt & Co. Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Brattlen

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JUL 20 1929

DO NOT WRITE IN THIS SPACE
State File No. 66811

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5572
(No.) Pocatello General Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Blanche Maxine Hudson
(a) Residence. No. 427 N. Bannock St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~
6. DATE OF BIRTH (month, day and year): May 14, 1929
7. AGE: Years | Months | Days: 0 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Pocatello Idaho

PARENTS
10. NAME OF FATHER: Ernest H. Hudson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Colorado
12. MAIDEN NAME OF MOTHER: Irma Bowers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Arkansas

14. Informant: E. H. Hudson
(Address): Pocatello Idaho
15. Filed 5/23, 1929. J. Manning Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 23 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to May 23, 1929
that I last saw her alive on May 23, 1929
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Icterus Neonatorum
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Will Brotherton, M. D.
5-23-, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cem. | Date of Burial: 5/24/29
20. Undertaker: D. L. McHan | Address: Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66812

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5571

(No.) 164
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Elma Paulsgrove

(a) Residence. No. 606 N. Garfield St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. ~~Single, Married~~ Widowed, or ~~Divorced (write the word)~~

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 25, 1853

7. AGE: Years 76 | Months 2 | Days 25 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Unknown Hansen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. C. E. McGee
(Address) Pocatello Idaho

15. Filed 5/23, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 21, 1929
that I last saw h[illegible] alive on May 20 1929
and that death occurred, on the date stated above, at 5 p. m.
The CAUSE OF DEATH* was as follows:
Senility
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Paraplegia
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Blackfoot Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. F. Howard, M. D.
5/22, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cem. | Date of Burial: 5/23/29
20. Undertaker: H. L. McHan | Address: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66813

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 3570
(No. Pocatello Gen Hosp)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alvin Earl Stillson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 21 1882

7. AGE: Years 46 | Months 10 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Topeka Kansas

PARENTS

10. NAME OF FATHER: Samuel E. Stillson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Nora E. Belling
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New York

14. Informant: Mrs A. Anderson
(Address): Pocatello Idaho

15. Filed May 20 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1929, to May 19, 1929
that I last saw him alive on May 19, 1929
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:
Nephritis —
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Pneumonia —
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J. Young M. D.
5/20, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Ida — Date of Burial: May 22 1929
20. Undertaker: MC Hansen & Co — Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66814

PLACE OF DEATH
County Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161

Local Registrar's No. 5569

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert O Graham

(a) Residence. No. 605 N. Garfield St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 21 1857

7. AGE Years 71 Months 5 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER A. C. Graham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Margaret Oliver
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs Carl Bryan
(Address) 605 N. Garfield

15. Filed 5/21, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 18/29 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1-29, 19..., to May 18, 1929
that I last saw him alive on May 17, 1929
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH was as follows:
Chronic Valvular
Heart Disease

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility.

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C P Groom, M. D.
5/20, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountainview Cem | Date of Burial May 20/29

20. Undertaker W. L. McHan | Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66815

RECEIVED JUL 20 1929

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

Registration District No. 28

Primary Registration District No. 216

(No. PORTNEUF RIVER)

Local Registrar's No. 5568

(If death occurred in a hospital or institution, give its name instead of street and number.)

142

2. FULL NAME LLOYD R. WESTCOTT

(a) Residence. No. 704 - So. HAYES AVE. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) MAR. 15, 1918

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	11	1	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work AT SCHOOL

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ST. ANTHONY IDA.

PARENTS

10. NAME OF FATHER ROYAL E. WESTCOTT

11. BIRTHPLACE OF FATHER (city or town) (State or Country) IOWA.

12. MAIDEN NAME OF MOTHER EDITH ANDERSON

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UTAH

14. Informant ROYAL E. WESTCOTT

(Address) 704 - So. HAYES AVE. POCA. IDA.

15. Filed 5/17, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MAY. 1, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____

that I last saw h____ alive on ____, 19____

and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Accidental Drowning in Portneuf River

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur W Hall M. D.

5/17, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW CEMETERY	MAY. 17, 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No.

PLACE OF DEATH

County of Bannock

City of Chesterfield Ida

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 2161

Local Registrar's No. 161

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME George W. Upchurch

164 66816

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec 23-1843

7 AGE: Years 86 | Months 6 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North C.

PARENTS

10 NAME OF FATHER: Wesley Upchurch

11 BIRTHPLACE OF FATHER (city or town) (State or country): United States

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U. S.

14 Informant: Minnie Upchurch
(Address) Chesterfield Ida

15 Filed July 31, 1929 Mrs. G. G. Fitz
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 26 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 19, to , 19, that I last saw h alive on , 19, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
General debility - old age
Been gradually failing
little over 6 wk (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Chesterfield Ida

Date of Burial: June 28 1929

20. Undertaker

Address

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66817

PLACE OF DEATH
County of Bannock
City of Lava Hot Springs
Registration District No. 84
Primary Registration District No. 2160
Local Registrar's No. 160

(No.) 49
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wallace Walton Flemming

(a) Residence. No. St. Ririe Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Flemming

6. DATE OF BIRTH (month, day and year): May 10, 1854.

7. AGE: Years 75 | Months 2 | Days 3 | If LESS than 1 day, hrs, or min:

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farming
(c) Name of employer: None.

9. BIRTHPLACE (city or town) (State or country): Oil City Pennsylvania

PARENTS

10. NAME OF FATHER: Hiram Flemming
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pennsylvania
12. MAIDEN NAME OF MOTHER: Nancy Hogue
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pennsylvania

14. Informant: Ada Smith
(Address) Idaho Falls

15. Filed July 31, 1929 Mrs. G. G. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to July 13, 1929, that I last saw him alive on July 12, 1929, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:
Cancer of Prostate (Carcinomatous)
(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary): None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes no Date of June 9, 1929
Was there an autopsy?
What test confirmed diagnosis? Examination of tumor

(Signed) C. A. Rich, M. D.
7-13, 1929. (Address) Lava Hot Springs.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66818

Local Registrar's No. 139

PLACE OF DEATH

County of Bannock
City of Lava Hot Springs
Registration District No. 84
Primary Registration District No. 2161
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

201

2. FULL NAME Mona LaPreal Monsen

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 30, 1926.

7. AGE Years	Months	Days	If LESS than 1 day,
2	7	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Aberdeen Idaho

PARENTS

10. NAME OF FATHER Lorin Peter Monsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mt. Pleasant Utah
12. MAIDEN NAME OF MOTHER Glyda LaPreal Jackman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salem Utah

14. Informant Lorin P. Monsen
(Address) Lava Hot Springs

15. Filed July 21, 1929 Mrs. E. E. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4, 1929, to July 5, 1929, that I last saw her alive on July 5, 1929, and that death occurred, on the date stated above, at 4 55 a. m.

The CAUSE OF DEATH* was as follows:
Fracture of base of skull.
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Run over by car.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Examination

(Signed) C. A. Rich, M. D.
7-5, 1929 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66819

PLACE OF DEATH
County of Bannock
City of Lava Hot Springs
Registration District No. 84
Primary Registration District No. 2161
Local Registrar's No. 15-8
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Thelda Berniece Avery.

(a) Residence. No. .... St. ....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
1	5	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lava Hot Springs Ida.

PARENTS

10. NAME OF FATHER John Jefferson Avery
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lava Hot Springs Idaho.
12. MAIDEN NAME OF MOTHER Helen Berniece Dast.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Garland Utah.

14. Informant Jeff Avery
(Address) Lava Hot Springs

15. Filed July 31, 1929 Mrs. G. I. Fife Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22, 1929, to June 25 1929
that I last saw her alive on June 25, 1929
and that death occurred, on the date stated above, at 12 M. p. m.
The CAUSE OF DEATH* was as follows:
Pneumonia
Lobar type

(duration) .... yrs. .... mos. 3 ds.
CONTRIBUTORY (Secondary) None
(duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? No Date of ....
Was there an autopsy? No.
What test confirmed diagnosis? X-Ray Examination

(Signed) C A Birch M. D.
June 25, 1929 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66822

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bannock Registration District No. 84
City of Lava Hot Spring Primary Registration District No. 216
(No.)
Local Registrar's No. 155

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Joseph Henry Byington

(a) Residence. No. St. 1613

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Rosetta Byington

6 DATE OF BIRTH (month, day and year) Dec 28 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheep grower
(b) General nature of industry, business, or establishment in which employed (or employer) Sheepraising
(c) Name of employer None

9 BIRTHPLACE (city or town) Ogden
(State or country) Utah

PARENTS

10 NAME OF FATHER Hiram Byington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Hanna D Harr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jackson Co. Missouri

14 Informant Mrs. Rosetta Byington
(Address) Lava Hot Springs Idaho

15 Filed June 2, 1929 Mrs G G Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 3 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1929, to May 3, 1929,
that I last saw ~~him~~ alive on May 3, 1929,
and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF ~~DEATH~~* was as follows:
Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Examination

(Signed) C A Rich M. D.
May 3, 1929. (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66823

PLACE OF DEATH
County of Bannock Registration District No. 84
City of Lava Hot Springs Primary Registration District No. 2161
(No.) Local Registrar's No. 154
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ward Reese Day

(a) Residence. No. Arimo - Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept 5. 1920

7 AGE: Years 8 | Months 7 | Days 28 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Schoolboy.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Downey

PARENTS
10 NAME OF FATHER Fred Day.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond, Utah
12 MAIDEN NAME OF MOTHER Edith Halverson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond, Utah

14 Informant Fred Day
(Address) Arimo - Idaho

15 Filed June 7. 1929 Mrs. G. G. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 3 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 3, 1929, that I last saw h... alive on May 3, 1929, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:
Drowning - Accidental
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) None
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Dorothy Reed, M. D.
May 3, 1929 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66826

Registration District No. 28
Primary Registration District No. 2191
Local Registrar's No. 3605

PLACE OF DEATH
County of BANNOCK
City of POCATELLO
(No. ST. ANTHONY HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME GRACE STUART FRIER

(a) Residence. No. TYHEE, IDAHO, St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of WM J. FRIER

6. DATE OF BIRTH (month, day and year) MAY 12, 1864

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
65	1	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work HOUSEWIFE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ENGLAND

PARENTS
10. NAME OF FATHER JOHN J. WATERFALL
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ENGLAND
12. MAIDEN NAME OF MOTHER SUSANA BACON
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ENGLAND

14. Informant W. C. STUART
(Address) TYHEE, IDAHO.

15. Filed 6/21, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JUNE (Month) 23, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21, 1929, to June 23, 1929
that I last saw h[illegible] alive on June 22, 1929
and that death occurred, on the date stated above, at 3 9 m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
Arteriosclerosis
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) O. F. Lee, M. D.
6/24, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW CEMETERY	6-25-1929
20. Undertaker	**Address**
ARTHUR W. HALL	POCATELLO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66827

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 216
Local Registrar's No. 5604
(No. 436 W. Sheridan)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Otto Christoffersen 49

(a) Residence. No. 436 W. Sheridan St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 17, 1852

7. AGE: Years 78 | Months 6 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: retired R.R.
(b) General nature of industry, business, or establishment in which employed (or employer): Shop employee
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10. NAME OF FATHER: Lerne Christoffersen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Chris Christoffersen
(Address) Pocatello, Ida

15. Filed June 22 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 20 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to June 20th, 1929, that I last saw h[illegible] alive on June 20th, 1929, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:
Prostatic Carcinoma
Cardio Vascular Renal Disease
(duration) 3 yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
What was there an autopsy? No
What test confirmed diagnosis?

(Signed) H. Daniels, M. D.
June 22, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Ida — Date of Burial: June 22 1929

20. Undertaker: H. L. McHan — Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66828

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5603

(No. 219-WEST YOUNG ST.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME BONNIE M. THOMAS

(a) Residence. No. 219-WEST YOUNG St. 119
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE

4. COLOR OR RACE: WHITE

5. Single, Married, Widowed, or Divorced (write the word): SINGLE

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) JAN. 21, 1929

7. AGE Years 0 Months 5 Days 0 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer) INFANT

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) POCATELLO. IDA.

PARENTS

10. NAME OF FATHER R. C. THOMAS

11. BIRTHPLACE OF FATHER (city or town) (State or Country) MISSOURI

12. MAIDEN NAME OF MOTHER MABEL SUTTON

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) IDAHO.

14. Informant R. C. THOMAS
(Address) 219-WEST YOUNG POCA. IDA.

15. Filed 6/21, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JUNE (Month) 20, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 20, 1929
that I last saw her alive on June 20, 1929
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D C Ray, M. D.

6-21, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: MOUNTAIN VIEW CEMETERY POCA. IDA. Date of Burial: 6-23 1929

20. Undertaker: ARTHUR W. HALL Address: POCATELLO

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 28

DO NOT WRITE IN THIS SPACE
State File No. 66829

PLACE OF DEATH

County of BANNOCK
City of POCATELLO
Registration District No. 28
Primary Registration District No. 241
(No. 1135- NORTH MAIN ST.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 5602

2. FULL NAME ANDREW O INGELSTROM

(a) Residence. No. 1135- NORTH MAIN St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of MARIA E. JACOBSON

6. DATE OF BIRTH (month, day and year) OCT. 10, 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	75	8	9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work RETIRED
(b) General nature of industry, business, or establishment in which employed (or employer) MERCHANT
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) SWEDEN

PARENTS

10. NAME OF FATHER OLAF INGELSTROM
11. BIRTHPLACE OF FATHER (city or town) (State or Country) SWEDEN
12. MAIDEN NAME OF MOTHER ERIGNA ANDERSON
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) SWEDEN

14. Informant MRS. MARIA INGELSTROM
(Address) 1135- NORTH MAIN ST. POCA. IDA.

15. Filed 6/24, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JUNE 19, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to June 19, 1929
that I last saw h[illegible] alive on June 18, 1929
and that death occurred, on the date stated above, at 4 9 m.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
Myocarditis
(duration) yrs. 6 mos. — ds.
CONTRIBUTORY (Secondary) age
(duration) — yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of no
Was there an autopsy? no
What test confirmed diagnosis? Physical findings
(Signed) [signature], M. D.
6-21, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
BASALT, IDAHO.	JUNE 23, 1929
20. Undertaker	Address
ARTHUR W. HALL	POCATELLO.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66830

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 216
Local Registrar's No. 560
(No. 442 E. Hayden)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carmina Gianchetta

(a) Residence. No. 442 E. Hayden
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 1st 1868

7. AGE: Years 61 | Months 5 | Days 12 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10. NAME OF FATHER: Agostino Corrado
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Italy
12. MAIDEN NAME OF MOTHER: Maddalena Chiocchetti
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy

14. Informant: Joseph Gianchetta
(Address) 442 E. Hayden

15. Filed 6/22, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15, 1929, to June 13, 1929
that I last saw her alive on June 11, 1929
and that death occurred, on the date stated above, at 4.30 P.M.
The CAUSE OF DEATH* was as follows:
Cancer of Liver
(duration) 1 yrs. — mos. — ds.
CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical findings
(Signed) [illegible], M. D.
6-14, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: June 16 1929
20. Undertaker: Schumacher & Beasley — Address: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 20 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66831

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2141
Local Registrar's No. 5599
(No.) Pocatello General Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert Budas Jr

(a) Residence. No. Roberts 202 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed or divorced
HUSBAND of (or) WIFE of Esther Budas

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23		15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Salesman (autos)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Red Lodge Montana

PARENTS
10. NAME OF FATHER: Albert Budas Sr
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Catherine Renn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn.

14. Informant: Esther Budas
(Address) Red Lodge Montana

15. Filed 6/17, 1929 J. H. Fleming Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to June 16, 1929
that I last saw h[illegible] alive on June 16, 1929
and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:
Fracture Base of Skull
accidental
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (over)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis? Clinical + inspection

(Signed) H. E. Howard, M. D.
6/17, 1929 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Billings, Montana	
20. Undertaker H. K. McClain	Address Pocatello Idaho

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66832

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 741
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5598

2. FULL NAME Esther Elizabeth Hooper

(a) Residence. No. 720 - So 2nd Avenue St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of E. B. Hooper

6. DATE OF BIRTH (month, day and year) February 3-1908

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	21	3	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Union Oregon

PARENTS

10. NAME OF FATHER Joseph McElroy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Ellen Horn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Box Elder County Utah

14. Informant E. B. Hooper
(Address) 720 - So 2nd Ave Pocatello

15. Filed 6/14, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 13, 1929
that I last saw her alive on June 13, 1929
and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:
Acute Peritonitis
(duration) yrs. 1 mos. 1 ds.
CONTRIBUTORY (Secondary) Rupture of Fallopian tube
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? Yes Date of June 12 1929
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) J. F. Villeen, M. D.
June 14 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Union Oregon	
20. Undertaker	Address
Arthur W Hall	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66833

Local Registrar's No. 5597

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 214

(No. General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

133

2. FULL NAME Joseph H Byington

(a) Residence. No. Hailey Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ann Cooley

6. DATE OF BIRTH (month, day and year) November 30-1852

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	6	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake City Utah

PARENTS

10. NAME OF FATHER Joseph Henry Byington

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Nancy Ann

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Joseph H Byington

(Address) Hailey Idaho

15. Filed 6/15, 1929. J H Feeney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to June 12, 1929

that I last saw her alive on June 12, 1929

and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Dilated Stomach

Intes- obstruction

Removed G.B.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. GB.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Rockland

Did an operation precede death? Yes Date of 6/12/29

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H C Swan, M. D.

6/15, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rockland Idaho	June 16 1929
20. Undertaker	Address
Arthur W Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66834

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5596

2. FULL NAME Wayne Humphrey

(a) Residence. No. Crystal Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

175

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 11 1924

7. AGE 4 Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Crystal Idaho
(State or country)

PARENTS
10. NAME OF FATHER W. W. Humphrey
11. BIRTHPLACE OF FATHER (city or town) Dayton Washington
(State or Country)
12. MAIDEN NAME OF MOTHER Margaret Hargert
13. BIRTHPLACE OF MOTHER (city or town) Walla Walla Washington
(State or Country)

14. Informant W. W. Humphrey
(Address) Crystal Idaho

15. Filed 6/11 1929 J. M. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Alkaloid Poison from eating wild passings (accidental)
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Arthur W Hall Coroner ~~M.D.~~
6/11, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Crystal Idaho Date of Burial 6/11/29

20. Undertaker H. L. McCain Pocatello Idaho Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Wayne Humphrey

now lying buried in Crystal Cemetery, in the City or Town of Crystal(Arbon Valley)

County of Power State of Idaho, who died on the 9 day of June, 1929, Aged ____ years ____ months

____ days, the cause of death being Accidental poisoning and not directly or indirectly by diphtheria;(membranous croup);scarlet fever;smallpox;leprosy;asiatic cholera;typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

Arthur W. Hall, Coroner attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private
private or railway conveyance

to Restlawn Memorial Gardens Cemetery in the City or Town of Pocatello County of Bannock

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Power it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 20th day of May, A.D. 19 77.

Permit issued to:
Manning Funeral Chapel
520 North Twelfth Ave.
Pocatello, Idaho 83201

Janet M. Wick
by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City,

Town or County of ____ State of Idaho, this ____ day of ____, 19__.

Health Officer

FORM BH 56-019

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66835

Local Registrar's No. 3595

Registration District No. 28

Primary Registration District No. 2161

PLACE OF DEATH

County of Bannock

City of Near Downey

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1896

2. FULL NAME Rula Ireland Andrus

(a) Residence. No. Ucon, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 17, 1908

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	2	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work student and general housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ucon, Idaho

PARENTS

10. NAME OF FATHER Robert Andrus

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Lovenia Boden

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Robert Andrus

(Address) Ucon, Idaho

15. Filed 6/11, 1929. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 7 [illegible] m.

The CAUSE OF DEATH* was as follows: Fractured Skull, auto overturned in highway near Downey corpse found. (accidental)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur W Hall Coroner M.D.

6/11, 1929 (Address) Pocatello.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ucon, Idaho	June 12 1929

20. Undertaker Jack A. Wood Address Idaho Falls, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66836

PLACE OF DEATH
County of Benewah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 22

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Thomas Cannell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Dec 2

7. AGE: Years 83 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: retired Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) England
(State or country) Iolanand

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant James Frame
(Address) St Maries Ida.

15. Filed July 22, 1929 O. E. Ellerman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28, 1929, to July 22, 1929
that I last saw him alive on July 22, 1929
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Senility -
(Just seemed not to have vitality sufficient to withstand disease, etc.) (duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) Benign Hypertrophy of Prostate (duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) C A Robins, M. D.
July 24, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Woodlawn
Date of Burial: July 25 1929

20. Undertaker: O. E. Ellerman for Geo E. Mitchell
Address: St Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

PLACE OF DEATH

County of Benewah

City of St. Joe

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

DO NOT WRITE IN THIS SPACE

State File No. 66837

Local Registrar's No. 21

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Gale Scott

164

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) June 8 - 1838

7. AGE 91 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Rancher

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10. NAME OF FATHER Jonas Scott

11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....

12. MAIDEN NAME OF MOTHER French.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant Rev. Orland Scott
(Address) Loppinich Wash.

15. Filed July 2, 1929. O. Meager, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to —, 19..., that I last saw him ~~alive~~ dead on July 2, 1929 and that death occurred, on the date stated above, at 12:15 m.

The CAUSE OF DEATH* was as follows:

General senility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) O. Meager Coroner, M. D.

July 2, 1929 (Address) St Maries Idg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Woodlawn | Date of Burial: July 5 1929

20. Undertaker: Mitchell & Meager | Address: St Maries Idg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

PLACE OF DEATH

County of Bennah

City of St Maries

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 66838

Local Registrar's No. 20

74a

2. FULL NAME Edward J. Shanahan

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About 56 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Fire patroleman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Coeur d'Alene Timber Protective Assn

9. BIRTHPLACE (city or town) (State or country): not known

PARENTS

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): not known

14. Informant: Pete Sinrude
(Address): Fernwood Ida

15. Filed July 2, 1929 O. Meroger Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1st (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1929, to ——, 19..., that I last saw him dead on July 1st, 1929 and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:
Found dead along side road two miles east of Emida Ida
Cause of his death was probable apoplexy
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
..... (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) O. Meroger Coroner M. D.

July 2, 1929 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grand Rapids Mich
Date of ~~Burial~~ Shipment: July 4 1929

20. Undertaker: Mitchell & Meroger
Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66839

PLACE OF DEATH
County of Benewah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 19

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Axel Johnson 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Brita Olivia Larson

6. DATE OF BIRTH (month, day and year): Feb 12.

7. AGE: 60 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Lumber Scaler
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: St. Maries Mill Co.

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10. NAME OF FATHER: Axel Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: (Brita Olivia Larson)
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Mrs. Axel Johnson
(Address): St Maries Ida

15. Filed July 1, 1929 O S Meraw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-30, 1929, to 6-30, 1929
that I last saw him alive on 6-30, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Heart block
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G G Espe, M. D.
7-1, 1929 (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashland Wise
Date of Burial: Marvel

20. Undertaker: Mitchell & Meraw
Address: St Maries Ida

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66846

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 127
Primary Registration District No. 2194

Local Registrar's No. 144

(No. 904)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Stewart

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 31, 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	Stillborn			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot, Ida

PARENTS

10. NAME OF FATHER Robert Percy Stewart
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Susan May Shelman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Washington

14. Informant X Robert Percy Stewart
(Address) Blackfoot R. R. #2

15. Filed Aug 1, 1929 W. Walter Coburn Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1929, to July 31, 1929
that I last saw h Stillborn, 1929
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

Atelectasis of Lungs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Lungs would not get no air into them

(Signed) W W Beck, M. D.
7/31, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Groin city cemetery	Aug 1, 1929
20. Undertaker E J Funk	Address Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

172432 D

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66841

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 191
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 143

2. FULL NAME ELLA C WAMSTAD 90

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of CARL O WAMSTAD

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day,
47	5	25	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work HOUSEWIFE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Peter Kollman,

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER ----

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Grace A. Clippinger R.N.
(Address) BLACKFOOT, IDAHO

15. Filed July 29 1929 W. McCaleb E. Cate Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JULY 28th, 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 24th, 1929 to July 28th 1929
that I last saw her alive on July 28th, 1929
and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Ges. Williams M. D.
July 29, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Caldwell Ida — Date of Burial 19

20. Undertaker: Modern Mortuary — Address Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1929

PLACE OF DEATH

County of Bingham

City of Blackfoot

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66842

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 142.

(No. 306 Judicial Street, County Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Strong White. (Indigent)

(a) Residence. No. County Hospital 306 W. Judicial St. Street

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Heber White. (Deceased)

6. DATE OF BIRTH (month, day and year): Dont know

7. AGE: Years 72 | Months --- | Days --- | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): England.

PARENTS

10. NAME OF FATHER: Dont know.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. D.E.Gibby (Stepdaughter)

(Address) Blackfoot, Idaho.

15. Filed July 27, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 27, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1923, to July 27, 1929 that I last saw her alive on July 26, 1929, and that death occurred, on the date stated above, at 9:15 A m.

The CAUSE OF DEATH* was as follows:

Cancer of the intestines.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Epilepsy

(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Dont know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. E. Patrick, M. D.

Jul. 27, 1929 County Physician (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: G.C.Cem., Blackfoot, Ida. Date of Burial: Jul. 29 1929

20. Undertaker: E. J. Frank Address: Blackfoot,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66843

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bingham
City of Blackfoot ~~Route 2~~

Registration District No. 121
Primary Registration District No. ~~2144~~ 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 141.

2. FULL NAME Rose Myrtle Evans Rose Myrtle Evans 57

(a) Residence. No. 86 Francis St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: W. S. Evans

6 DATE OF BIRTH (month, day and year): Dec. 1870

7 AGE: Years 58 | Months 7 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Utah

PARENTS
10 NAME OF FATHER: David Nichol
11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland
12 MAIDEN NAME OF MOTHER: May Duncan
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: William E. Evans
(Address): Blackfoot. Ida.

15 Filed July 26, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 24 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1929, to July 24, 1929, that I last saw her alive on July 24, 1929, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mel

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) T. Mitchell, M. D.
July 25, 1929 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Riverside Thomas Cem.
Date of Burial: 7-27-1929

20. Undertaker: Modern Mortuary, Blackfoot. Ida
Address

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 8 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 1007
(No. East Court St.)

State File No. 66844
Local Registrar's No. 140
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kent Bowman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: July (Month) 23 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Earl Bowman

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Zina Campbell

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Earl Bowman
(Address): Blackfoot Ida

15. Filed July 24 1929 Mrs Walter E. Cole Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1929 to July 24 1929, that I last saw him alive on July 24 1929, and that death occurred on the date stated above, at 12:20 A.M.
The CAUSE OF DEATH* was as follows:

Premature birth
6 months
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Working with a shovel
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C W Peck M. D.
7/24 1929 (Address) Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: G. C. Conn — DATE OF BURIAL: July 26 1929

20. UNDERTAKER: Acting Kent Bowman — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66845

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 139

70

2. FULL NAME Maydee Miller

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. ..... mos. 11 ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph F Miller

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 35			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) ---

PARENTS

10. NAME OF FATHER Jim Green

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo

12. MAIDEN NAME OF MOTHER ---

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant Grace A. Clapsaddle R-N.
(Address) Blackfoot, Idaho.

15. Filed July 23, 1929 Mollie Eaton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 22nd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10th 1929 to July 22nd 1929
that I last saw her alive on July 21st, 1929
and that death occurred, on the date stated above, at 1:05 AM
The CAUSE OF DEATH* was as follows:

Encephalitis

Don't know (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Geo. DeFranco, M. D.
July 22nd, 1929 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Pampa Idaho	
20. Undertaker	Address
E J Peck	Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19

RECEIVED AUG 8 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66846

Local Registrar's No. 138

1. PLACE OF DEATH
County of Bingham
City of Pingree
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patricia Ann Jackrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single
6. DATE OF BIRTH: July (Month) 21 (Day) 1929 (Year)
7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 5 hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Pingree Ida
10. NAME OF Father: David Norman Jackrell
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Thora Samuelson
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. W. Samuelson
(Address): Sandy Utah
15. Filed July 21 1929 Mrs. Viola E. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1929 to July 21 1929
that I last saw her alive on July 21 1929
and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:

Premature birth
6th mo
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Automobile Riding
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W W Beck M. D.
7/21/1929 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ingell Idaho
DATE OF BURIAL: July 24 1929
20. UNDERTAKER: Adams
ADDRESS: Sandy Ut.
J. W. Samuelson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 8 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bingham
City of Pingree
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)

State File No. 66847
Local Registrar's No. 137
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thora Fackrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: July (Month) 21 (Day) 1929 (Year)

7. AGE: — Yrs. — Mos. — ds. — IF LESS than 1 day how many 3 hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Pingree Idaho

10. NAME OF Father: David Norman Fackrell

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Thora Samuelson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J V Samuelson
(Address) Sandy Utah

15. Filed July 21 1929 Mrs Walter E Cates
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1929 (Year) 161a

17. I HEREBY CERTIFY, That I attended deceased from July 21 1929 to July 21 1929, that I last saw her alive on July 21 1929 and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Premature birth 6th mo
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Automobile Riding
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.
7/21 1929 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pingree Idaho
DATE OF BURIAL: July 21 1929

20. UNDERTAKER: Acting J V Samuelson
ADDRESS: Sandy Ut

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66848

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. South Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 136

76

2. FULL NAME MARY E JONES

(a) Residence. No. ..... St. Paris, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): WIDOW

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: David Jones

6. DATE OF BIRTH (month, day and year)

7. AGE: About 104 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wales

PARENTS
10. NAME OF FATHER: ---
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ---
12. MAIDEN NAME OF MOTHER: ---
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ---

14. Informant: Grace A. Clippinger R.N.
(Address) Blackfoot, Idaho.

15. Filed July, 16, 1929 Mrs Walter [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: JULY 15th, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 4th, 1929, 19 to July 15th 1929, 19
that I last saw her alive on July 14th 1929, 19
and that death occurred, on the date stated above, at 5:10 PM m.
The CAUSE OF DEATH* was as follows:

Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
July 16, 1929 (Address) Blackfoot,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Paris, Ida. | Date of Burial: July, 18, 29 19

20. Undertaker: Modern Mortuary | Address: Blackfoot.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66849

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 135

164

2. FULL NAME Ann Britton
(a) Residence. No. No. E. Main St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of John W. Britton

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
87	0	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS
10. NAME OF FATHER Thos O'Roruke
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Margaret Tracy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Amelia B. Wilson
(Address) Blackfoot Ida

15. Filed July 16, 1929 Mrs Walter E. Latine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 14 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1929 to July 14, 1929
that I last saw her alive on July 14, 1929
and that death occurred, on the date stated above, at 10 A. m.
The CAUSE OF DEATH* was as follows:
Senility
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Old age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F. M. Mitchell, M. D.
July 15, 1929 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Groce City Cem. Date of Burial: July 20 1929

20. Undertaker: Modern Mortuary Address: Blackfoot

FORM V. S. No. [illegible] RECEIVED AUG 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ..... , ... St.)

File No. 66850

Registered No. 134

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clifta Fackrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 23 (Day) 1923 (Year)

7. AGE: 6 Yrs. 4 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: P P Fackrell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rachel Reese

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P P Fackrell

(Address) Blackfoot R F D #2

15. Filed July 15 1929 McWalter E Catered Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1929, to July 14 1929 that I last saw her alive on July 14 1929 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis with general anasarca

..... (Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary) Infected Tonsils

..... (Duration) ..... yrs. 8 mos. ..... ds.

(Signed) J. O. Hampton M. D.

7-15 1929 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverside Thomas

DATE OF BURIAL: July 16 1929

20. UNDERTAKER: E T Peck

ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66853

PLACE OF DEATH
County of BLACKFOOT
City of BINGHAM

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 192

(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

746

2. FULL NAME SARAH JONES

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 19 yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 79			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS

10. NAME OF FATHER ---
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ---
12. MAIDEN NAME OF MOTHER ---
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ---

14. Informant Grace A. Clippinger R.N.
(Address) Blackfoot, Idaho.

15. Filed July 16, 1929 Mrs Walter E. Cates Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 12th, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1928, 19..., to July 12th 1929, 19...
that I last saw her alive on July 11th 1929, 19...
and that death occurred, on the date stated above, at 3.45 AM m.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Two days (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Senility
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? No Date of ...
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
July 12th 1929 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery — Date of Burial: 7/16 1929
20. Undertaker: E J Funk — Address: Blackfoot
24 hrs

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66854

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194.
Local Registrar's No. 121

(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

38

2. FULL NAME BEN FELTS

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About 44 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sheep Herder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Warrensburg Mo

PARENTS
10. NAME OF FATHER: William B Felts
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ---
12. MAIDEN NAME OF MOTHER: Margaret Sanders
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ---

14. Informant: Grace A. Clippinger R.N.
(Address) Blackfoot, Idaho

15. Filed July 13, 1929 Mr Walter E. Caterel Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 12th, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Mar 6th 1928, 19 to July 12th 1929, 19
that I last saw him alive on July 12th 1929, 19
and that death occurred, on the date stated above, at 2:05 P m.
The CAUSE OF DEATH* was as follows:
Syphilis
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Don't know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
July 12th, 1929 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Gem city cemetery
Date of Burial: July 14 1929

20. Undertaker: E. P. Peck
Address: Blackfoot Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 8 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66855

County of Bingham
City of Blackfoot.
Registration District No. 121
Primary Registration District No. 219H
Local Registrar's No. 120

(No.) 90
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marjorie Barnard

(a) Residence. No. Rich Lane St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 7. 1925.

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	7	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot. Ida.

PARENTS

10. NAME OF FATHER John N. Barnard.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Elizabeth E. Allen.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant J M Barnard
(Address) Blackfoot. Ida.

15. Filed July, 11, 1929. Mrs Walter E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July, 10, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to July 10, 1929
that I last saw her alive on May 6, 1929
and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. 9 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W W Beck, M. D.
July, 11, 1929. (Address) Blackfoot.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grove City Cem.	7-12-29.

20. Undertaker	Address
Modern Mortuary	Blackfoot

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66856

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bigham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 129.

2. FULL NAME Eva Mauch

164

(a) Residence. No. West Center St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of Daniel Mauch

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 76 | Months 4 | Days 0 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): House wife
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS
10 NAME OF FATHER: Gottlid Zink
11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia
12 MAIDEN NAME OF MOTHER: Henretta Richter
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: G. D. Mauch
(Address) Blackfoot, Idaho

15 Filed July 6, 1929 Mrs Waters Dietrich
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 5 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1929, to July 5, 1929, that I last saw her alive on July 5, 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. A. Mitchell, M. D.
7/5/, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Riverside Thomas Cem
Date of Burial: July 6 1929

20. Undertaker: E J Peck
Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1929

PLACE OF DEATH

County of Bingham

City of Presto Precinct.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66857

Local Registrar's No. 128

182

2. FULL NAME Dean Victor Park.

(a) Residence. No. Presto, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Infant.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 2, 1928

7. AGE

Years	Months	Days	If LESS than 1 day,
1	4	3	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Presto, Idaho

PARENTS

10. NAME OF FATHER Glen E. Park

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City, Utah

12. MAIDEN NAME OF MOTHER Irene Brookbush.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iona, Idaho.

14. Informant Mrs William A. Brookbush

(Address) Goshen, Idaho

15. Filed July 7, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 5, 1929. 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ Investigated death, July 5, 1929 ~~that I last saw him alive on~~ ....., 19..

and that death occurred, on the date stated above, at 10: A m.

The CAUSE OF DEATH* was as follows:

Drowned- accidental- in irrigation canal.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) W. E. Patrick, M. D.
County Health Officer

..... 19.. (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rose Hill Cemetery, Idaho Falls, Idaho,

Date of Burial: July 7 19..

20. Undertaker: Jack A. Wood

Address: Idaho Falls, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66858

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 127

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dorothy Pearson

161a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) July 3, 1929

7. AGE Years | Months | Days | If LESS than 1 day, 6 hrs. or — min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Blackfoot Idaho

PARENTS

10. NAME OF FATHER Lee R. Pearson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rexburg Idaho
12. MAIDEN NAME OF MOTHER Dorothy Hazel Bird
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Yost Utah

14. Informant .....
(Address) Lee Pearson Rexburg Ida

15. Filed July 2, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3, 1929, to July 4, 1929 that I last saw her alive on July 3, 1929 and that death occurred, on the date stated above, at 3:00 a m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Automobile riding.

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) W W Beck, M. D.
July 5, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rexburg Idaho | Date of Burial 19

20. Undertaker: E J Peck | Address: Blackfoot

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66859

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 126.

76

2. FULL NAME JULIA C HIBBARD
(a) Residence. No. ..... St. POCATELLO, IDAHO
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): WIDOW

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Hibbard

6. DATE OF BIRTH (month, day and year) May. 30. 1865

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
64	1	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ---- Smithfield Utah,

PARENTS

10. NAME OF FATHER Willis Lemon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ---- Ohio
12. MAIDEN NAME OF MOTHER Annie Homer ~~Willis Lemon~~
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) --- Ohio,

14. Informant Grace A Clippinger R.N.
(Address) BLACKFOOT, IDAHO

15. Filed July 1, 1929 Mrs Arthur E. Fabrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 1 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from April 4th, 1928, 19 to July 1st, 1929
that I last saw her alive on July 1st, 1929, 19
and that death occurred, on the date stated above, at 12:45 P m.
The CAUSE OF DEATH* was as follows:
Paralysis of the Insane
3 weeks (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
July 1st, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rexburg. Idaho.
Date of Burial: 7-3- 29 19

20. Undertaker: Modern Mortuary By Joseph T. Fitzpatrick
Address: Blackfoot.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

current complete June 1929

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66860

PLACE OF DEATH

County of Ft. Hall Reservation Idaho
City of
Registration District No. 121-R
Primary Registration District No. 2194-R
Local Registrar's No. 125

(No. -------)
(If death occurred in a hospital or institution, give its name instead of street and number.)

179

2. FULL NAME Charles Eagle.

(a) Residence. No. ----- St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Shoshone Ind. 4/4	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Hahnewop.

6. DATE OF BIRTH (month, day and year) ---- 1844

7. AGE	Years	Months	Days	If LESS than 1 day,
	85	--	--	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Victoria Watson,
(Address) Blackfoot, Idaho.

15. Filed July 22, 1929 M. Slater Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 13, 1929
(Month) (Day) (Year)

No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 11: P m.

The CAUSE OF DEATH* was as follows:

Nephritis,-Chronic.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) ----
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Henry P. Cokell, M. D.
, 19 (Address) Ft. Hall, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ft. Hall Reservation,	6/17/1929
20. Undertaker	Address
Brown Eldredge Co.,	Blackfoot, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

current complete June 1929

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66861

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation Idaho

City of

Registration District No. I2I-R

Primary Registration District No. 2I94-R

Local Registrar's No. 12

(No. -----)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Tommie Tissidimit.

(a) Residence. No. --- - St. ----
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6. DATE OF BIRTH (month, day and year) --- 1907

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
22	--	--	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ft. Hall Reservation

PARENTS

10. NAME OF FATHER: Charles Tissidimit

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Lemhi Reservation

12. MAIDEN NAME OF MOTHER: Mary Use

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Lemhi Reservation

14. Informant: Charles Tissidimit.
(Address) Ft. Hall. Idaho.

15. Filed July 22, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June II, 1929 (Month) (Day) (Year) 19

Treated by Lynn Bros, Pocatello

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at 2: A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Omentu m (Glandular)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Appendicitis

(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/24/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Henry R. Wheeler, M. D.

..., 19... (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ft. Hall Reservation

Date of Burial: 6/I4/29 19

20. Undertaker: Shomaker & Beasley, Pocatello

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66862

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 30

PLACE OF DEATH
County of Blaine
City of Hailey
(No. 129)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lily Ann Fleming

(a) Residence. No. / St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 2-

7. AGE — Years: 58 | Months: 4 | Days: 26 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Cloverdale Nevada

PARENTS

10. NAME OF FATHER: Henry Brasse
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Sophia Dalton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Hazel Rockwell
(Address) Hailey Idaho

15. Filed 7-31, 1929 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/27, 1929, to 7/28, 1929
that I last saw her alive on 7-28, 1929
and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:
Accidental gasoline explosion burns 2/3 of Body area
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) negligible
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) E. W. Fox, M. D.
7/30, 1929 (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey Idaho — Date of Burial: July 30 1929
20. Undertaker: Harris & Canon — Address: Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

PLACE OF DEATH

County of Blaine

City of Bellevue

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66863

Registration District No. 57

Primary Registration District No. 2022

Local Registrar's No. 29

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

159e

2. FULL NAME Burys

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): 3/20-29

7. AGE: Years | Months | Days: 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bellevue, Elda

PARENTS

10. NAME OF FATHER: David Le Grande Burys

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mammoth Utah

12. MAIDEN NAME OF MOTHER: Ireta Thomander

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ephraim Utah

14. Informant: Ireta Burys
(Address): Bellevue, Elda

15. Filed 7-31, 1929 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/20, 1929, to 3/22, 1929

that I last saw her alive on 3/22, 1929

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of head. No occipital bone — and a hydrocephalus

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Wolf, M. D.

5/22, 1929 (Address) Hailey, Elda

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66864

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Blaine
City of Ketchum

Registration District No. 57
Primary Registration District No. 2022
(No.)
Local Registrar's No. 28

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Baby Nielson

(a) Residence. No. / St. 161a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year): 7 - 14 1929

7 AGE — Years ✓ | Months ✓ | Days ✓ | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ketchum, Ida.

PARENTS

10 NAME OF FATHER: Thoren P. Nielson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Utah
12 MAIDEN NAME OF MOTHER: Jean Cartmel
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Colo.

14 Informant: Robert H. Wright M.D.
(Address): Hailey, Ida.

15 Filed 7-31, 1929 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 7 (Month) 14 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 7-14, 1929, to 7-14, 1929, that I last saw him alive on 7-14, 1929, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

7 months Premature -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Robert H. Wright M. D.
7-15, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Ketchum, Ida — Date of Burial: 7-15 1929

20. Undertaker: Family & Friends — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66865

PLACE OF DEATH
County of Boise
City of
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alexander Feltzner

(a) Residence. No. Idaho City Ida., St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 16. 1862

7. AGE	Years	Months	Days	If LESS than 1 day,
	66	9	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Graefenhaft Glatz
(State or country) Kaning Reich Bohemia

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant
(Address)

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

"The CAUSE OF DEATH" was as follows:* Heart Failure (Died in a location where a Doctor could not be reached to determine real cause) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L. A. Schlosser, Coroner, M. D.
, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho City Ida.	Aug 4 1929
20. Undertaker None	Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66866

PLACE OF DEATH
County of Bonner
City of Priest River

Registration District No. 85
Primary Registration District No. 2185.
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 27

2. FULL NAME Louis Major

90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE: Years 62 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Woodsman.
(b) General nature of industry, business, or establishment in which employed (or employer): Logging
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Priest River Hospital
(Address): Priest River, Idaho.

15. Filed July 25, 1923 R. E. Wessa L. A. Moon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) — 25 (Day) — 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to July 25, 1929 that I last saw him alive on 7-24-, 1929 and that death occurred, on the date stated above, at 12 30 PM.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) 5 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Dr. R. A. Lower, M. D.

7-25, 1929 (Address) Priest River Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Priest River, Idaho. | Date of Burial: July 31, 1929

20. Undertaker: Moon Mortuary | Address: Sandpoint, Idaho

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66867

PLACE OF DEATH

County of Bonner
City of Laclede

CERTIFICATE OF DEATH

Registration District No. 85
Primary Registration District No. 2185
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 26

147

2. FULL NAME James O'Gara.

(a) Residence. No. Laclede, Idaho. St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Josephine O'Gara

6 DATE OF BIRTH (month, day and year) July 27, 1854

7 AGE Years 74 Months 11 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Necedah. Wisconsin

PARENTS
10 NAME OF FATHER Peter O'gara
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs. Josephine O'Gara
(Address) Laclede, Idaho

15 Filed July 22, 1929 R. E. Wessa. L. G. Moon Dep. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 20 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at 10:9 m.
The CAUSE OF DEATH* was as follows:
Accidental Traumatism: Struck by Railway Passenger Train.
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) L. G. Moon Coroner.
July 21, 1929 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Priest River, Idaho. Date of Burial July 22, 1929

20. Undertaker Moon Mortuary Address Sandpoint Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 5 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66868

Local Registrar's No. 25

County of Bonner

City of Priest River

Registration District No. 85

Primary Registration District No. 2185

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Grant Harrington

(a) Residence. No. 90 St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 50			

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant R. E. Wessa

(Address) Priest River, Idaho

15 Filed July 12, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 3, (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Natural Causes:

Probable unknown Chronic Heart Disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. H. Moon Coroner M. D.

July 5, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Woodmen Cemetery — Date of Burial: July 13 1929

20. Undertaker: Moon Mortuary — Address: Priest River, Ida.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66869

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
(No.)
Local Registrar's No. 24

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ottelia Henrietta F. Doolittle

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lafayette S. Doolittle

6 DATE OF BIRTH (month, day and year) Dec. 23, 1887

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	6	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rice Lake, Wis.

PARENTS

10 NAME OF FATHER Henry Wielep

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Euphrazina Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lafayette S. Doolittle
(Address) Priest River, Idaho

15 Filed July 6, 1929 L. E. Wessa
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 2, (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:
Accidental Traumatisms:
Overturning of auto down embankment. Six miles north of Priest River (Pines Creek bridge
CONTRIBUTORY (Secondary) Main Branch Highway.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) L. H. Moon Coroner.
July 3, 1929 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: I.O.O.F. Cemetery — Date of Burial: July 7, 1929

20. Undertaker: Moon Mortuary — Address: Priest River, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 5 1929

PLACE OF DEATH

County of Bonner

City of Priest River

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 85

Primary Registration District No. 2185

(No.)

DO NOT WRITE IN THIS SPACE

State File No. 66870

Local Registrar's No. 23

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Infant of Mr. & Mrs. Jerome Farr

161a

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 2, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Priest River, Idaho

PARENTS

10 NAME OF FATHER Jerome Farr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ponsford Minn.

12 MAIDEN NAME OF MOTHER Lucile Wahl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denver Colo.

14 Informant Jerome Farr.

(Address) Priest River, Ida.

15 Filed July 3, 1929 R. E. Wessa.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 2 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to July 2, 1929, that I last saw h.. alive on July 2, 1929, and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) J. A. Lower, M. D.

July 3, 1929 (Address) Priest River

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Residence — Date of Burial: July 3 1929

20. Undertaker: Jerome Farr, Father — Address: Priest River

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66871

PLACE OF DEATH

County of Bonner
City of Laclede

CERTIFICATE OF DEATH

Registration District No. 85
Primary Registration District No. 2185
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 23

2. FULL NAME John Eik

(a) Residence. No. ..... St. 90 Spokane, Wn.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Eik

6 DATE OF BIRTH (month, day and year): Jan. 18, 1888

7 AGE: Years 41 | Months 5 | Days 13 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Norman County Minn.

PARENTS
10 NAME OF FATHER: Jacob Eik
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: Bertha Orthun
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: U J Eik
(Address) Absaroka, Mont

15 Filed July 3, 1929 R. E. Wessa, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 1st (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at 12:15 P.m.

The CAUSE OF DEATH* was as follows:
Natural; Causes Unknown.
Probable Chronic Heart Disease.
..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? .....
(Signed) L. A. Moon Coroner
July 1st, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Columbus, Montana
Date of Burial: 19

20. Undertaker: Moon Mortuary
Address: Priest River, Ida

Exact statement of OCCUPATION is very important. See instructions on back of certificate.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66872

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78 —
Primary Registration District No. 2155
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

57

2. FULL NAME Samuel A Thomas
(a) Residence. No. 72I N Third St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Ida Thomas

6. DATE OF BIRTH (month, day and year) May 17 ~~1866~~ 1863

7. AGE Years 66 Months 2 Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS
10. NAME OF FATHER John Thomas.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois.
12. MAIDEN NAME OF MOTHER unobtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant John Thomas
(Address) Sandpoint Ida.

15. Filed July 25, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 23 (Day) 1929 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from For many years 7/23 1929
that I last saw him alive on July 22, 1929
and that death occurred, on the date stated above, at 7:30 A m.
The CAUSE OF DEATH* was as follows:
Diabetes -

over 8 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. P. Stackhouse, M. D.
7-24-, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lakeview cemetery
Date of Burial 7-25 1929

20. Undertaker Turnbull Co
Address Sandpoint

RECEIVED AUG 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66873

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 215

Local Registrar's No.

(No. 310 Church St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

145-B

2. FULL NAME John Melvin Harbison

(a) Residence. No. ~~307~~ 310 Church St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 8 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sandpoint Idaho

PARENTS

10. NAME OF FATHER John M Harbison
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montana
12. MAIDEN NAME OF MOTHER Ethel Crowder
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs Ruby Wells
(Address) Sandpoint Idaho

15. Filed July 12 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) II (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1929, to July 11, 1929, that I last saw him alive on July 11, 1929 and that death occurred, on the date stated above, at 7:00P m.

The CAUSE OF DEATH* was as follows:

Inanition.
Forceps delivery of
occiput posterior presentation
Cord strangulation.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. P. Stackhouse, M. D.
7-12-, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	July 13 1929
20. Undertaker Turnbull Co	Address Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66874

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No. Sandpoint Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

90

2. FULL NAME Ralph Spring Sr.

(a) Residence. No. Sandpoint, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Spring

6. DATE OF BIRTH (month, day and year) 1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	10	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Cedar Timber.

(c) Name of employer

9. BIRTHPLACE (city or town) Toronto
(State or country) Canada.

PARENTS

10. NAME OF FATHER Kinein Spring

11. BIRTHPLACE OF FATHER (city or town) Toronto
(State or Country) Canada.

12. MAIDEN NAME OF MOTHER Hannah Heron

13. BIRTHPLACE OF MOTHER (city or town) Toronto
(State or Country) Canada.

14. Informant Ralph Spring Jr.
(Address) Sandpoint, Idaho

15. Filed July 22, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr /, 1929, to July 16, 1929
that I last saw him alive on July 16, 1929
and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Cardio-vascular-renal
disease

many (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. P. Staeckhouse, M. D.
July 17, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane, Washington	July 1929

20. Undertaker Smith & Co., Spokane, Washington. Address
I. C. Moon Mortuary Sandpoint Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66875

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No. 510 S. Florence Avenue)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wilhelmina Rothenfluh

(a) Residence. No. Sandpoint, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank Rothenfluh

6. DATE OF BIRTH (month, day and year) 1860

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	--	--	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Berlin, Germany.

PARENTS

10. NAME OF FATHER Michael Leske

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Frank Rothenfluh
(Address) Sandpoint Idaho.

15. Filed July 22 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 13, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
July 8th 1929 to July 13 1929
that I last saw her alive on July 12th 1929
and that death occurred, on the date stated above, at 2:21 P. m.

The CAUSE OF DEATH* was as follows:
Acute arthritis Rheumatism

(duration) yrs. Alive mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) H. D. Evans M. D.
7-13- 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	July 16, 1929

20. Undertaker	Address
L.G. Moon' [illegible],	Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66876

PLACE OF DEATH

County of Bonner

City of Dover

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Mary Elizabeth Brown

(a) Residence. No. Dover, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Daniel Brown

6. DATE OF BIRTH (month, day and year) 1866, May 10.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	2	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER James Mararity

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.

12. MAIDEN NAME OF MOTHER Charlotte Phillips

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Daniel Brown
(Address) Dover, Idaho

15. Filed July-10, 1929 Floyd A. Wendle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 10, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16th, 1929, to July 9, 1929, that I last saw h-er alive on July 9th, 1929, and that death occurred, on the date stated above, at 6:00 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) W. B. Evans M. D.

July 10, 1929 (Address) Bonners Ferry, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	July 12, 1929

20. Undertaker	Address
Moon Mortuary,	Sadpoint, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66877

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Nels Olson

(a) Residence. No. Sandpoint, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Marie Olson

6. DATE OF BIRTH (month, day and year): 1832

7. AGE: 97 Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Arvika, Sweden

PARENTS

10. NAME OF FATHER: Olaf Nelson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Carrie Nelson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden.

14. Informant: Mrs Norman Campbell
(Address) Sandpoint, Ida.

15. Filed July 10, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend, 19 to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 10:15 P.m.

The CAUSE OF DEATH* was as follows:
Chronic Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Floyd G. Wendle M. D.

July-10, 1929 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery — Date of Burial: July 12, 1929

20. Undertaker: Moon Mortuary, Sandpoint, Idaho. — Address

RECEIVED AUG 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66878

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No. Kootenai, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Mrs. Francis Arianna Gunter

(a) Residence. No. Sandpoint, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Gunter

6. DATE OF BIRTH (month, day and year) 1844-Aug. 31.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	10	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pulaski County, New York

PARENTS

10. NAME OF FATHER Sylvester Doane

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rupert Vermont

12. MAIDEN NAME OF MOTHER Sarah Ann Fuller

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pawlett Vermont

14. Informant Mrs L. Piatt
(Address) Kootenai, Ida

15. Filed July 22, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month), 13, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to July 7, 1929
that I last saw her alive on July 7, 1929
and that death occurred, on the date stated above, at 7:45 P. m.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease with Bronchial Trouble

(duration) yrs. mos. 13 ds.
CONTRIBUTORY (Secondary) Old Age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) C E Clawson M. D.
7-16, 1929 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	July 18, 1929
20. Undertaker	**Address**
L.G. Moon	Sandpoint, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66879

PLACE OF DEATH
County of Butte
City of near Darlington

Registration District No. 59
Primary Registration District No. 2129
Local Registrar's No. 8
(No. 14)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ephraim C. Lindsay

(a) Residence. No. Meadows, Utah St. Near Darlington, Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Barton Lindsay
6. DATE OF BIRTH (month, day and year): Aug 28, 184[illegible]
7. AGE: Years 47 | Months 8 | Days 24 | If LESS than 1 day, hrs. or X min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer & Veterinary
(b) General nature of industry, business, or establishment in which employed (or employer): X
(c) Name of employer: X
9. BIRTHPLACE (city or town) (State or country): Brigham City Utah

PARENTS
10. NAME OF FATHER: Edwin A Lindsay
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wisconsin
12. MAIDEN NAME OF MOTHER: Editha Morgan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Mrs Sarah Laburn
(Address): Meadow Utah
15. Filed June 6, 1929. T C Salt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to June 7, 1929
that I last saw h[illegible] alive on June 3, 1929
and that death occurred, on the date stated above, at 7 15 Pm.
The CAUSE OF DEATH* was as follows:

Spotted Fever

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Carroll A Jensen, M. D.
June 4, 1929 (Address) Mackay Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meadow, Utah — Date of Burial: June 8 1929
20. Undertaker: Theo R Garner — Address: Mackay, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66880

PLACE OF DEATH

County of Butte
City of Arco Idaho

CERTIFICATE OF DEATH

Registration District No. 59
Primary Registration District No. 2129
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 6

2. FULL NAME Mary Gray Beck

(a) Residence. No. Arco Idaho St. 101a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femine
4 COLOR OR RACE: American
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of J. W. Beck

6 DATE OF BIRTH (month, day and year) Jan. 16, 1880

7 AGE: 49 Years; Months 5; Days 15; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lewistown New York

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) (State or country) New York Niagara Falls
12 MAIDEN NAME OF MOTHER Don't Know.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lewistown New York

14 Informant John Gray White
(Address) 440 E - 3rd So Salt Lake City Ut.

15 Filed June 2, 1929 T. C. Salt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 2 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1929, to June 2, 1929, that I last saw her alive on June 2, 1929, and that death occurred, on the date stated above, at 2:45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Lab. & Physical Exam
(Signed) I. R. Egbert, M. D.
June 2, 1929 (Address) Arco Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Provo Utah
Date of Burial: 19

20. Undertaker: E T Peck
Address: Blackfoot Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66882

PLACE OF DEATH
County of Butte
City of Moore

Registration District No. 59
Primary Registration District No. 2129
Local Registrar's No. 5
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gottlob ~~Mitchell~~ Michel Laubenstein. H3

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 16, 1858

7. AGE: Years 71, Months 3, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Fredonia Wisconsin

PARENTS
10. NAME OF FATHER: Jacob Laubenstein
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.
12. MAIDEN NAME OF MOTHER: Ann Margrate Stehr
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany.

14. Informant: Leona Wheeler
(Address): Moore, Idaho

15. Filed May 7, 1929. T. C. Salt, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1929, to May 5, 1929
that I last saw him ~~alive~~ dead on May 5, 1929
and that death occurred, on the date stated above at 4 15 A. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Face
(left face and ear)
..... (duration) 2 yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary): Myocarditis
..... (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 1928
Was there an autopsy? no
What test confirmed diagnosis? Pathological section
(Signed) J. R. Egbert, M. D.
May 5, 1929 (Address) Arco Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Arco, Idaho
Date of Burial: May 7, 1929

20. Undertaker
Address

WRITE EN RECORD

N. B.—Every item of information s o . AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so nat it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66883

PLACE OF DEATH
County of Butte
City of Arco
Registration District No. 59
Primary Registration District No. 2129
Local Registrar's No. 4
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME John Todd Welch

(a) Residence. No. Arco Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ora Curr

6. DATE OF BIRTH (month, day and year) May 17 1860

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69		10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) General
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hudson Mich.

PARENTS

10. NAME OF FATHER Horrace Welch
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fairfield Ohio
12. MAIDEN NAME OF MOTHER Charlotte Van Akin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hudson Mich.

14. Informant L W Van Akin
(Address) 42 Lockport Ida

15. Filed May 30, 1929 T Sallee Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to May 27, 1929, that I last saw him alive on May 27, 1929, and that death occurred, on the date stated above, at 3 15 - P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Laboratory & Physical

(Signed) Dr R Egbert M. D.
May 29, 1929 (Address) Arco Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Arco Idaho	May 29 1929
20. Undertaker	Address
Theo. Garner	Arco, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 22 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Butte — Registration District No. 59

City of near Howe — Primary Registration District No. 2129

(No. ..... , ... St.) — File No. 66884

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hattie Foster — Registered No. 3.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: wt

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH: Feb. (Month) 2 (Day) 1861 (Year)

7. AGE: 67 Yrs. 7 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Nathan Foster

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Mary Philbrick

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs John Dietrich

(Address) Howe, Idaho

15. Filed March 10, 1929 — T. C. Ball, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1929 — Mar (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 19..., to ✓ 19..., that I last saw h... alive on ✓ 19..., and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Primarily Stroke Paralytic

(Duration) 4 Yrs. 3 mos. 6 ds.

Contributory (Secondary): Stroke

(Duration) ... yrs. ... mos. 6 ds.

(Signed) Edna Tucker Coroner

3-5-1929 (Address) Arco Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 6 mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? unknown

Former or usual residence Carbondale, Kansas

19. PLACE OF BURIAL OR REMOVAL: Carbondale, Kansas — DATE OF BURIAL: Mar. 9 1929

20. UNDERTAKER: Theo. R. Garnis — ADDRESS: Arco, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 22 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Butte

City of Arco

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

File No. 66885

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George L. Rider

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: wt.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Unknown (Month) (Day) 1869 (Year)

7. AGE: 60 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. D. Martin

(Address) Arco, Ida.

15. Filed Feb. 26, 1929

T. C. Salt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1928 to Feb 25 1929, that I last saw him alive on Feb 25 1929, and that death occurred on the date stated above, at 28 M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary) Rheumatism

(Duration) 2 yrs. mos. ds.

(Signed) F. E. Barrett M. D.

2/26 1929 (Address) Arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arco Idaho

DATE OF BURIAL: Feb. 26 1929

20. UNDERTAKER: Theo. R. Garnin License 233

ADDRESS: Arco, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66886

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

2. FULL NAME Peter C. M. Anderson

(a) Residence. No. Arco, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 14 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

44a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Anderson

6. DATE OF BIRTH (month, day and year) June 2. 1874

7. AGE: 54 Years, Months 8, Days 9. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ephraim Utah

PARENTS

10. NAME OF FATHER: Andrew M. Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Maria Larson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Josephine Anderson
(Address) Arco Idaho Box 5

15. Filed Feb. 12, 1929. T. C. Salt, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb, 1927, to Feb 5, 1929
that I last saw him alive on Feb 5, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Chronic Endocarditis
..... (duration) 5 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Influenza
..... (duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Phy Exam
(Signed) F. E. Garrett, M. D.
Feb 12, 1929 (Address) Arco Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shelley, Ida. Date of Burial: Feb. 13 1929

20. Undertaker: Theo. R. Garnier Address: Arco, Ida.

RECORDED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66887

PLACE OF DEATH

County of Butte

City of Moore

Registration District No. 59

Primary Registration District No. 2129

Local Registrar's No. 11

(No. 187)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gloria Mae Andersen

(a) Residence. No. near Moore, Idaho St.
(Usual place of abode)

Length of residence in city or town where death occurred. 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	wh.	Single

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of V

6. DATE OF BIRTH (month, day and year) Aug. 6 - 1927

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	11	22	4 hrs. or — min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gyrum, Utah

PARENTS

10. NAME OF FATHER Sylvan E. Andersen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Gyrum, Utah

12. MAIDEN NAME OF MOTHER Bessie M. McAffee

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wallsburg, Utah

14. Informant Sylvan Andersen
(Address) Moore Idaho

15. Filed July 30, 1929. J. Ball Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to July 29, 1929, that I last saw her ~~alive~~ dead on July 29, 1929, and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:

Drowning
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no What test confirmed diagnosis? Physical examination

(Signed) W. C. Egbert, M. D.

July 30, 1929 (Address) Arco Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66888

PLACE OF DEATH
County of Butte
City of Moore

Registration District No. 59
Primary Registration District No. 2129
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

129

2. FULL NAME Charles Wesley ~~Wood~~ Watson

(a) Residence. No. Moore, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE wt
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) unknown

7. AGE Years 66 Months ✓ Days ✓ If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS
10. NAME OF FATHER Cradmitter Watson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Margaret Dale
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Mrs M E Woody
(Address) 340 North Arthur

15. Filed Pocatello Ida July 28, 1929 T. Salt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to July 28, 1929
that I last saw him alive on July 21, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical exam - Laboratory
(Signed) F. R. Egbert, M. D.
July 29 1929 (Address) Arco Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Arco, Idaho
Date of Burial July 29 1929

20. Undertaker Theo. R. Garnier
Address Arco, Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5- RECEIVED AUG 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Butte

City of Howe

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59

Primary Registration District No. 2129

(No. ....., ... St.)

File No. 66889

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Merton Stanley 88B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: int

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Divorced (Write the word.)

6. DATE OF BIRTH: 7 (Month) 9 (Day) 1864 (Year)

7. AGE: 64 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: D. B. Stanley

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Stanley

(Address) Howe, Idaho

15. Filed Feb. 10, 1929

T. C. Salt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1928 to July 16 1928 that I last saw him alive on July 16 1928 and that death occurred on the date stated above, at about ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute Gastritis

..... (Duration) 1 yrs. ..... mos. 1 ds.

(Signed) F. E. Barrett M. D.

1/27 1929 (Address) Arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Howe, Idaho

DATE OF BURIAL: Jan. 24 1929

20. UNDERTAKER: Theo. R. Garnier

ADDRESS: Arco, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JUL 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 6689G

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Kunas
City of Fairfield

Registration District No. 58
Primary Registration District No. 2136
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Marjorie E. Cunninghame

(a) Residence. No. Fairfield Ida St. 161A
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan 14-29

7 AGE Years | Months | Days | If LESS than 1 day, 4 hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Fairfield Ida.

PARENTS

10 NAME OF FATHER Cecil Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington

12 MAIDEN NAME OF MOTHER Vera E. Leaper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Soldier Ida.

14 Informant Mrs. Robt. Leaper
(Address) Fairfield Ida.

15 Filed Jan 30, 1929 Earl F Perkins
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. (Month) 15 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1929, to Jan. 15, 1929, that I last saw her alive on Jan. 14, 1929, and that death occurred, on the date stated above, at 3:30a m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) A. B. Sheets, M. D.

Jan. 16, 1929 (Address) Fairfield Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66891

PLACE OF DEATH

County of Lamas

City of Fairfield Ida.

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Florence McHan

149

(a) Residence. No. Fairfield Ida. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Earnest McHan

6 DATE OF BIRTH (month, day and year)

7 AGE 27 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10 NAME OF FATHER C. U. Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant C. L. Bach

(Address) Fairfield Ida.

15 Filed March 1929 Pearl L. Perkins Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. (Month) 28 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1928, to Feb. 28, 1929, that I last saw her alive on Feb. 28, 1928, and that death occurred, on the date stated above, at 1-15a m.

The CAUSE OF DEATH* was as follows: Shock following child birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Placenta Previa with Hemmorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Rapid dilatation + extraction Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. S. Sheets M. D.

Mar. 1, 1929 (Address) Fairfield Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Freewater Oregon

Date of Burial Mar 1929

20. Undertaker H. L. McHan

Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 7 1929

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66893

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 79

(No. Mercy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Betty Joan Shryack

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug. 1st 1929

7. AGE: Years | Months | Days: 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nampa Idaho

PARENTS

10. NAME OF FATHER: W. W. Shryack

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Urpha Marie Kelly

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wisconsin

14. Informant: W. W. Shryack

(Address): Melba, Idaho

15. Filed 8/1, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Aug 1, 1929 that I last saw her alive on Aug 1, 1929 and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

8 Mo baby x (1 Mo premature)
Breathed internally & drowned.
Congestion lungs.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Premature 1 mo.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Horace P Bilhup, M. D.

Aug 1, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa. Date of Burial: 8-2 1929

20. Undertaker: Wm D. Talley Address: Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 7 1929

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66894

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 80

(No. Mercy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

126

2. FULL NAME Glenn. Geo. Watson

(a) Residence. No. 424-12 Ave No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 2. - 1918.

7. AGE

Years	Months	Days	If LESS than 1 day,
10	8	25	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: school-boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mont Pelier Idaho

PARENTS

10. NAME OF FATHER John. G. Watson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Susie Welker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bloomington Ida.

14. Informant Mrs. J. G. Watson

(Address) 424-12th Ave No. Nampa.

15. Filed 7/29, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 27th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19, 1929, to July 27, 1929 that I last saw him alive on July 27, 1929 and that death occurred, on the date stated above, at 11:55 m.

The CAUSE OF DEATH* was as follows: General Periodonitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis Operation 7-19-29

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Emma Symptoms

(Signed) V C Bellinger M. D.

July 29, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa

Date of Burial 19

20. Undertaker: Wm D. Talley

Address: Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66895

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 2006

Local Registrar's No. 87

(No. On train near Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

205-a

2. FULL NAME Hee Usterman

(a) Residence. No. R.F.D. No. 2 St. McMinnville, Oregon
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mina Usterman

6. DATE OF BIRTH (month, day and year): Nov. 13th 1862

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
66	7	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: self.

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: Dirk Usterman

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Frances Bauman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany.

14. Informant: Mrs. Mina Usterman
(Address) R.F.D. # 2. McMinnville, Oregon

15. Filed July 13, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Overdose of Dr Miles Pain Killer.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis? Opinion of County Physician

(Signed) Paul L. Case M.D.

July 13-29 19..... (Address) Coroner Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation,~~ or Removal: McMinnville, Ore.

Date of ~~Burial~~ Shipment: 7-13 1929

20. Undertaker: Wm D. Talley

Address: Nampa, Ida.

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66896

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. 107 - 17th ave. no)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 83

100a

2. FULL NAME Orval C. Hoffman

(a) Residence. No. 107 - 17th ave no St.
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 1st 1928

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Idaho

PARENTS

10. NAME OF FATHER Christian H. Hoffman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Copenhagen Denmark
12. MAIDEN NAME OF MOTHER Siene Vanleuven
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Elba Idaho

14. Informant Mr C. H. Hoffman
(Address) 107 - 17th Ave. no. Nampa, Ida.

15. Filed July 13, 1929 Bertha Conner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 8th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7 - 6, 1929, to 7 - 8, 1929
that I last saw h[illegible] alive on 7 - 7, 1929
and that death occurred, on the date stated above, at 9:50 A. m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia.
(duration) yrs. mos. 6 ds.
CONTRIBUTORY Pneumococcus
(Secondary)
Meningitis (duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) J. A. Porter, M. D.
7 - 9, 1929 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn - Nampa	7 - 10 1929
20. Undertaker	Address
Wm. D. Talley	Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66897

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 84

(No. 1431) (If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Ethel M. Terwilleger

(a) Residence. No. 1111 - 14 Ave So
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	married

5a. If married, widowed, or divorced, HUSBAND of ~~(or) WIFE of~~ G.E.

6. DATE OF BIRTH (month, day and year) April 9-1886

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston Minn

PARENTS

10. NAME OF FATHER Wm. Schwartz
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Guy E Terwilleger
(Address) 1111 - 14 ave So Nampa

15. Filed July 25, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-17, 1929 to 7-18, 1929
that I last saw her alive on 7-17-29, 19....
and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:
Septic Abortion

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of 7-17-29
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. C. Horton M. D.
7-23, 1929 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerdown Cem	7-29 1929
20. Undertaker	Address
Fred R Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66898

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hospt)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 82

2. FULL NAME Mary C Mullens

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

124

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Carl L.

6. DATE OF BIRTH (month, day and year): July 28

7. AGE: Years 50 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Phelps Mo.

PARENTS
10. NAME OF FATHER: Eliza Beckham
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: Honis unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Carl L. Mullens
(Address): Twin Falls Ida

15. Filed July 23, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1929, to July 17, 1929
that I last saw h..... alive on July 16, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Acute Nephritis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Cancer of Mediastinum
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? X ray
(Signed) Samuel A Swayne M. D.
Aug 5, 1929 (Address) Nampa, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlenburn Cem | Date of Burial: 7-19 1929

20. Undertaker: Fred & R Finson | Address: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

S. K.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 29 1929

State Board of Health File No. 66899

STATE OF UTAH—DEATH CERTIFICATE

1 PLACE OF DEATH

County Star Valley

Precinct or Village or Miles from Soda springs

Registration District no 82

City ..... No. ....., ... St., ... Ward [If death occurred in a hospital or institution give its NAME instead of street and number.]

2 FULL NAME Louise Griffin

(a) Residence. No. ..... St., ...
(USUAL PLACE OF ABODE) (IF NON-RESIDENT GIVE CITY OR TOWN AND STATE)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): single

5a If Married, Widowed, or Divorced HUSBAND OF (OR) WIFE OF

6 DATE OF BIRTH ....., 1..... (Month) (Day) (Year)

7 AGE 1 yrs. 4 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of Employer: Logan Utah

9 BIRTHPLACE (City or town) (State or Country)

PARENTS

10 NAME OF FATHER: Ralph Griffin

11 BIRTHPLACE OF FATHER (State or Country): Logan Utah

12 MAIDEN NAME OF MOTHER: Hilma Olson

13 BIRTHPLACE OF MOTHER (State or Country): Trenton Utah

14 Informant: J. P. Griffin
Address: 52 E. 2 South Logan Utah

15 Filed 7/17 1929 Dr Rubsel Tijert
Registrar

Registered Number 21 | No. of Burial or Removal Permit 22

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 12 (Day), 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from none attendent, 19....., to ....., 19.....,
that I last saw her alive on May 20, 1929,
and that death occurred, on the date stated above, at 12 9 m.
The CAUSE DEATH* was as follows:
strangled accidental
Child fell from bed and got
hung between bed and wall
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. C. Randall, M. D.
7/13, 1929 (Address) Logan Utah

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Millville Utah

DATE OF BURIAL: July 18, 1929

20 UNDERTAKER: B. M. Thomason

ADDRESS: Hyrum Utah

READ CAREFULLY INSTRUCTIONS ON BACK OF CERTIFICATE

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66900

PLACE OF DEATH

County of Caribou
City of SODA SPRINGS
Registration District No. 82
Primary Registration District No. 2159
Local Registrar's No. 17
(No. 126)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME HOMER B. NEILSEN ALSO KNOWN AS HOMER BENDIX NEILSEN

(a) Residence. No. ALEXANDER, IDAHO St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) SEPT. 7TH, 1908

7. AGE	Years	Months	Days	If LESS than 1 day,
	20	10	9	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work LABORER

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer H.L. FINCH

9. BIRTHPLACE (city or town) (State or country) BEAR RIVER CITY UTAH.

PARENTS

10. NAME OF FATHER BEN NEILSEN

11. BIRTHPLACE OF FATHER (city or town) (State or Country) DENMARK

12. MAIDEN NAME OF MOTHER CARRIE OLSEN

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) BRIGHAM CITY, UTAH.

14. Informant Ben. Neilsen
(Address) ALEXANDER, IDAHO

15. Filed JULY 16TH, 1929 Dr Russell Zigut
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JULY (Month) 16TH (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from JULY 14TH, 1929, to JULY 16TH, 1929
that I last saw him alive on JULY 16TH, 1929
and that death occurred, on the date stated above, at 4-A M m.
The CAUSE OF DEATH* was as follows:

PERITONITIS FOLLOWING ACCIDENT

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? YES Date of JULY 15TH 29
Was there an autopsy? NO
What test confirmed diagnosis?
(Signed) Dr Buckley, M. D.
JULY 16TH, 1929 (Address) SODA SPRINGS IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
SODA SPRINGS, IDAHO	1929 JULY 18TH
20. Undertaker E.D. WHITMAN	Address SODA SPRINGS IDAHO.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66902

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 16.

126

2. FULL NAME Theresa Perner
(a) Residence. No. Cumberland Wyoming
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Anton Perner
6. DATE OF BIRTH (month, day and year) Oct 15-1880
7. AGE Years 49 Months 8 Days 22 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Austria

PARENTS
10. NAME OF FATHER Jack Pangree
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Austria
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Austria

14. Informant Frances Perner
(Address) Rock Springs Wyo.
15. Filed 7-7-1929 Dr Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 6, 1929, to June 7, 1929
that I last saw he alive on June 6, 1929
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Pentamber
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Ruptured Gall Bladder
(duration) 2 yrs. mos. ds.
18. Where was disease contracted if not at place of death? 0
Did an operation precede death? yes Date of 7-6-29
Was there an autopsy? 0
What test confirmed diagnosis? X-Ray
(Signed) [illegible], M. D.
7-7-1929 (Address) Soda Springs Wyo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kemmerer Wyo Date of Burial 7-12-1929
20. Undertaker C. D. Whitman Address Soda Springs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66903

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 18

149

2. FULL NAME Elozia Maria Davis Orton
(a) Residence. No. Chesterfield Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William L. Orton

6. DATE OF BIRTH (month, day and year) May 5 - 1898

7. AGE Years 31 Months 2 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Soda Springs Idaho

PARENTS
10. NAME OF FATHER Albert C. Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Clifton Idaho.
12. MAIDEN NAME OF MOTHER Laura M. Hopkins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant William L. Orton
(Address) Chesterfield Idaho.

15. Filed 7-10-, 1929 Dr Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to June 5, 1929
that I last saw he alive on June 4, 1929
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:
Puerperal Sepsis

..... (duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) 0

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Chesterfield Idaho
Did an operation precede death? yes 0 Date of July 4, 1929
Was there an autopsy? .....
What test confirmed diagnosis? Physical Ex.
(Signed) Eric Karsky, M. D.
7/10/29, 19.... (Address) Soda Springs, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Idaho — Date of Burial 7-9 1929

20. Undertaker E. D. Whitman — Address Soda Springs Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66904

Local Registrar's No. 11

PLACE OF DEATH

County of Cassia

City of Oakley

Registration District No. 777

Primary Registration District No. 2176

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

#6 amended 03-12-08 ns

90

2. FULL NAME Fred W Larson

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Alice Larson

6. DATE OF BIRTH (month, day and year) June 8, 1880 ~~June 8 1929~~

7. AGE	Years	Months	Days	If LESS than 1 day,
	49		12	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grantsville Utah

PARENTS

10. NAME OF FATHER Gustave Larson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden

12. MAIDEN NAME OF MOTHER Annie Sophia Sunquist

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant Mary Alice Larson

(Address) Oakley Idaho.

15. Filed July 17, 1929 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to June 20, 1929, that I last saw him alive on June 20, 1929, and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) unknown yrs. mos. ds

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds

18. Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Charles B. Rayner, M.D.

July 15, 1929 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Oakley Idaho	June 23 19

20. Undertaker	Address
D. E. Johnson	Burley Ida

IDAHO DEPARTMENT OF HEALTH AND WELFARE
BUREAU OF HEALTH POLICY AND VITAL STATISTICS
AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

State of Utah } SS
County of Washington }

Certificate No. 29-66904

Date Filed July 20, 1929

The undersigned does solemnly swear that certain facts on the certificate of birth (Birth, Death, Marriage, etc.)

for Fred W Larson (Name on Original Certificate) who died (Was Born, Died, etc.) on June 20, 1929 (Date of Event)

in Oakley (Cassia Co.) (Place of Event)

are erroneous or were omitted.

ITEMS TO BE CORRECTED	FROM	TO
LIne 6 Deceased dated of birth	June 8, 1929	June 8, 1880

Subscribed and sworn to before me this 26 day of February 2008

Notary Public, X Linis Steed

Residing at St. George, UT.

My commission expires 2-23-09 (Seal)

X Gina Larson Heiner
Signature of Applicant

1526 N. Dixie Downs #2B
Street Address, City, State and Zip
St. George, UT. 84770

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____ } SS
County of _____ }

(Must be completed ☐) _____

(Is not necessary ☒) _____

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of _____, _____

Notary Public, _____

Residing at _____

My commission expires _____ (Seal)

_____
Signature of Applicant

_____
Street Address, City, State and Zip

02-22-08

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66905

PLACE OF DEATH
County of Lassen
City of Burley

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No,) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas. Wilson Jenkins

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W.	M

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Lillie Jenkins

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	8		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Goshen Ut.

PARENTS

10. NAME OF FATHER Chas L Jenkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Mary Conover
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Provo Nettie Elison

14. Informant Cathy
(Address)

15. Filed 6/10, 1929 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on 5-29, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Cancer of Head Pancreas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) Cheryl E. Dean, M. D.
May 29, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burial Dale	May 30 1929
20. Undertaker D E Johnson	Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66906

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Adelbert Cutler 129

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W.	M.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Ann Cutler

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	7	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Louisa Cutler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Sarah Ann Cutler
(Address) Burley

15. Filed May 31, 1929 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-25, 1929, to 5-27, 1929, that I last saw him alive on 5-27, 1929, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypert. Prostatic
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinic
(Signed) Lloyd E Dean, M. D.
May 29, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
N Ogden Ut	June 1 1929
20. Undertaker D E Johnson	Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PLACE OF DEATH

County of Lewis

City of Almo

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66907

Local Registrar's No.

2. FULL NAME Hanna Bell Bruesch

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Bruesch

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	10	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10. NAME OF FATHER Wm E. Johnstone

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Luella Bowls

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant J. J. Bruesch

(Address) Almo Ida

15. Filed 6/10/, 1929 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-2-, 1929, to 5-29-, 1929 that I last saw her alive on 5-29-, 1929 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dwight E Dean, M. D.

May 31, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Almo Ida	

20. Undertaker	Address
D E Johnson	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66908

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas Wesley Bailey 88B

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 85, Months 8, Days 23. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bean Penn.

PARENTS

10. NAME OF FATHER: Chas Bailey
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Jennie Whitaker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Muco Penn

14. Informant: Jacob C Kenney
(Address)

15. Filed 5/10, 1928 F. H. Carter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 22, 1929, to May 3, 1929
that I last saw him alive on May 3, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Not known
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas B Beymer, M. D.
, 19 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Blackfoot
Date of Burial: 19

20. Undertaker: E F Pack
Address: Blackfoot

RECEIVED JUL 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66909

PLACE OF DEATH
County of Minedoka
City of Rupert

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 179)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wm. Joseph Koeplin

(a) Residence. No. Burley St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M. Koeplin

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	6	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) Goverment
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Neb.

PARENTS

10. NAME OF FATHER Philip Koeplin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Elizabeth Koeplin
(Address) Burley

15. Filed 6/12/, 1929 F. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1929, to May 17, 1929
that I last saw him alive on May 16, 1929
and that death occurred, on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:

Electric Burn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E. H. Cooper, M. D.
May 24, 1929 (Address) Burley,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley	May 20 1929

20. Undertaker	Address
E. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66916

RECEIVED JUL 20 1929

County of Cassia

City of Burley

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

189 e

2. FULL NAME Harry Polland

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Not Known

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE	Years	Months	Days	If LESS than 1 day
	About 45			hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) " "
(State or Country)

14. Informant Paul Beer

(Address) Twin Falls

15. Filed 17, 1929 F. H. Coulter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17, 1929 to June 27, 1929
that I last saw him alive on June 27, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Fracture Base of Skull

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Auto accident

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph Dunstad, M. D.

July 18, 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burley Ida — Date of Burial: June 30 1929

20. Undertaker: Paul Beer. D. E. Johnson — Address: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 16 1929

PLACE OF DEATH

County of Cassia

City of Burley

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 119

Primary Registration District No. 2198

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 66912

Local Registrar's No.

2. FULL NAME Norman Isachson 90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 27, 1858

7. AGE — Years: 71 — Months: — Days: 15 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Ivar Isachson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway

12. MAIDEN NAME OF MOTHER Charlotte A Berg

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Nathaniel Hyer
(Address) Churchill Ida

15. Filed July 10, 1929 C. L. Slater Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to June 7, 1929
that I last saw him alive on June 5, 1929
and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:
Valvular heart disease

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) C. L. Slater, M. D.
June 21, 1929 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Albion Ida	June 11 1929
20. Undertaker	Address
W. A. Johnson	Burley

RECEIVED AUG 7 1929

PLACE OF DEATH

County of Clearwater

City of Orofino

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 2187

DO NOT WRITE IN THIS SPACE

State File No. 66913

Local Registrar's No. 86

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Crawford 64

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 8 1845

7. AGE	Years	Months	Days	If LESS than 1 day,
	84	4	16	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER James R. Crawford

11. BIRTHPLACE OF FATHER (city or town) (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant E. C. Crawford
(Address) Ansonia Ida

15. Filed 7/24, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17, 1929, to July 24, 1929
that I last saw him alive on July 17, 1929
and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Coroner

(Signed) C. J. Hopkins M. D.

7/26, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	July 27
20. Undertaker W. A. Shaw	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66914

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium) 910
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 87

2. FULL NAME John Seely

(a) Residence. No.) St. Moscow, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 0 mos. 18 ds. How long in U. S., if of foreign birth? 73 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Unascertained

6. DATE OF BIRTH (month, day and year) June 8, 1843

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86	1	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Small Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Brunswick - Canada

PARENTS

10. NAME OF FATHER Unascertained.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino — Idaho.

15. Filed 7/25, 1929. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1929, to July 23, 1929, that I last saw him alive on July 23, 1929, and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows: General arteriosclerosis

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Psychosis with Cerebral arterio-sclerosis (duration) ? yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs

(Signed) John Irvine McKelvey, M. D.
July 23 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	7-25-1929
20. Undertaker	**Address**
E. P. Short	Moscow

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66915

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2157
Local Registrar's No. 55

(No. Northern Idaho Sanitarium) 49B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Adams

(a) Residence. No. ..... St. St. Maries, Idaho-
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 12 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Unascertained

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day,
	60	?	?	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Common laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10. NAME OF FATHER Unascertained.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino — Idaho-

15. Filed 7/24, 1929. W. A. Thorn Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929 to July 21, 1929
that I last saw him alive on July 20, 1929
and that death occurred, on the date stated above, at 5.50 A. m.
The CAUSE OF DEATH* was as follows:
Chronic myocardiris

..... (duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Alcoholic psychosis, Chronic hallucinosis (duration) 19 yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John Irvine McKelvey, M. D.
July 21, 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
No. Ida. San. Cemetery	July 22 1929
20. Undertaker	Address
F. A. Billberg, Hosp. Attd.	Orofino - Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66916

PLACE OF DEATH

County of Clearwater
City of Ahsahka

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 84

(No.) 44B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Katy Crawford

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Femal	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of W. W. Crawford

6. DATE OF BIRTH (month, day and year) Sept 19 1866

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Iowa
(State or country)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town)
(State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant C. E. Crawford
(Address) Ahsahka

15. Filed July 22, 19 W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 21 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17, 1929, to July 21, 1929
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis, acute
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) R. T. Hollams, M. D.
July 26, 1929 (Address) Orofino.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	July 22
20. Undertaker	**Address**
W. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 7 1929

PLACE OF DEATH

County of Clearwater

City of Orofino

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 2177

DO NOT WRITE IN THIS SPACE
State File No. 66917

Local Registrar's No. 80

(No.) 91B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred D. Lindgren

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of E. E. Lindgren

6. DATE OF BIRTH (month, day and year) April 25 1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	61	2	27	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gothenburg Sweden

PARENTS

10. NAME OF FATHER Theodore Lindgren

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Anna Louise Larsen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Sarah Estelle Lindgren
(Address) Orofino Ida

15. Filed 7/22, 1929. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 19th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1927, to 7-19, 1929
that I last saw h~~im~~ alive on 7-19, 1929
and that death occurred, on the date stated above, at 6 1 p m.

The CAUSE OF DEATH* was as follows:
Cerebral Softening, Embolism and Thrombosis

(duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) Gonorrhea - Long hours worry - (duration) years mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) M. R. Fontaine, M. D.

7/21, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Veasman	7/22 1929
20. Undertaker W. D. Pinson	Address Orofino

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66918

PLACE OF DEATH

County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2107
Local Registrar's No. 52
(No. Northern Idaho Sanitarium) 483
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martha Woodfin

(a) Residence. No. ..... St. Latah Co., Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 21 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Woodfin

6. DATE OF BIRTH (month, day and year) ——— 1851

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER James M. Yarbrough
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained
12. MAIDEN NAME OF MOTHER Mary Elizabeth Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino — Idaho.

15. Filed 7/22, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to July 20, 1929
that I last saw her alive on July 20, 1929
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage. (Apoplexy).
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Psychosis with Cerebral arterio-sclerosis (duration) 20 yrs. + mos. + ds.

18. Where was disease contracted ✓ if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John Irvine McKelvey, M. D.
July 20, 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Palouse Hash	
20. Undertaker W. A. Shaw	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66919

PLACE OF DEATH

County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2157
Local Registrar's No. 91
(No. Northern Idaho Sanitarium) 74
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Esther Sowa

(a) Residence. No. ..... St. Lewiston, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) December 25, 1899

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29	6	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sauk Rapids, Minnesota.

PARENTS

10. NAME OF FATHER D. M. Sowa
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Hennika Libuda
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino — Idaho

15. Filed 7/18, 1929. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8, 1927, to July 18, 1929
that I last saw her alive on July 17, 1929
and that death occurred, on the date stated above, at 5.30 A. m.
The CAUSE OF DEATH* was as follows:
Status epilepticus
..... (duration) ✓ yrs. ✓ mos. 4 ds.
CONTRIBUTORY (Secondary) Epileptic psychosis
..... (duration) 17 yrs. ✓ mos. ✓ ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) Esther Grace McKelvey, M. D.
July 18, 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Lewiston Idaho	
20. Undertaker Orofino Mortuary	Address Orofino Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 7 1929

PLACE OF DEATH

County of Clearwater

City of Ahsahka

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 2187

DO NOT WRITE IN THIS SPACE
State File No. 66920

Local Registrar's No. 90

(No.) 90
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas Adams

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Indian	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Adams

6. DATE OF BIRTH (month, day and year) Sep 12 1855

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wash

PARENTS

10. NAME OF FATHER Chas Adams

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Emma Adams
(Address) Ahsahka

15. Filed 7/17, 1929. V. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 16 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:

Fell dead at side of road
Valvar Heart Dease
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) V. A. Shaw Coron M. D.
7/17, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ahsahka	July 19 1929

20. Undertaker V. A. Shaw Address Orofi

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66921

PLACE OF DEATH
County of Elegwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2176

Local Registrar's No. 79

(No. 75)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jessie Elizabeth Edmonson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Frank M. Edmonson

6. DATE OF BIRTH (month, day and year) June 30, 1883

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
46		13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Randolph County West Virginia

PARENTS

10. NAME OF FATHER A. D. Carr

11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia

12. MAIDEN NAME OF MOTHER Rhoda C. Snyder

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) West Virginia

14. Informant Frank Edmonson
(Address) Orofino

15. Filed 7/14, 1929. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1928, to July 13, 1929
that I last saw her alive on July 15, 1929
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:

Parasalysis agitans

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) R. J. Hopkins, M. D.
July 13, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cook County	7/15 1929
20. Undertaker	**Address**
H. A. Shaw	Orofino

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66922

PLACE OF DEATH

County of Clearwater
City of Pierce

Registration District No. 90
Primary Registration District No. 2187

Local Registrar's No. 78

(No. 142)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clarance Dinnis

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sep 2 1904

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ida

PARENTS

10. NAME OF FATHER Rube Dinnis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Org

12. MAIDEN NAME OF MOTHER Anna Birch

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash

14. Informant Litt Dinnis
(Address) Orofino, Ida

15. Filed 7/15, 1929. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 14 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:
Accdintal drown while in bathing

..... (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) H. A. Shaw Coroner, ~~M. D.~~
7/14, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fraser Cementry	7/16 19
20. Undertaker H. A. Shaw	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66923

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 77
(No. 164)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nancy Jane Chase

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Earnest Chase

6. DATE OF BIRTH (month, day and year): July 14 1862

7. AGE — Years: 66 | Months: 11 | Days: 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Meadville Pa.

PARENTS

10. NAME OF FATHER: Conrad
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unk
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Ray Burton Chase
(Address): Orofino

15. Filed 7/14, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-30, 1929, to 7-13, 1929
that I last saw h[er] alive on 7-13, 1929
and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:
Senility - Dementia Praecox
Terminal Pneumonia ?
Dont Know, No History
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Prolapsed Bladder
Uremia (duration) Dont Know yrs. mos. ds.

18. Where was disease contracted if not at place of death? Canada
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms

(Signed) W. T. Robertson M. D.
7/14, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Ida — Date of Burial 19

20. Undertaker: Brown Ware — Address: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66924

PLACE OF DEATH
County of Clearwater
City of Ahsahka

Registration District No. 90
Primary Registration District No. 2187

Local Registrar's No. 76

(No.) 184 C
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Irene Earle Blake

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Peter Blake

6. DATE OF BIRTH (month, day and year) April 25 1908

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	2	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Earl Fairley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Helen Parks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs E.E. Fairley
(Address) Peck Ida

15. Filed 7/11, 1929. H.A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 11 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:
Accidental killed when Auto left road going over the bank and crushin in head and skull

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H.A. Shaw Canna, M. D.
7/11, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	July 14 19
20. Undertaker	Address
Brower Wan	Lewiston

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66925.

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 75
(No.) 163
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Philipson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 47			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Clearwater Timber Co

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant W. A. Shaw Coroner
(Address) Orofin

15. Filed 7/12, 1929. W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 2.30 P m.
The CAUSE OF DEATH* was as follows:

Accidental killed with Dinamite
while blowing up stumps
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. A. Shaw Coroner M. D.
7/12, 1929 (Address) Orofin

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	July 13 19
20. Undertaker W. A. Shaw	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66926

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 74

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Morse 44

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs John Morse

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 64 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) X
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) X

14. Informant Mrs. Nelson
(Address) Orofino Ida

15. Filed 7/11, 1929 H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to July 8, 1929
that I last saw h alive on July 1, 1929
and that death occurred, on the date stated above, at 5:00 P m.
The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) C. J. Hopkins, M. D.
7/10, 1929 (Address) Orofino Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	7/11 1929
20. Undertaker W. D. Pinson	Address Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66927

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2187

Local Registrar's No. 73

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188 C

2. FULL NAME Junior James Welch

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 29 1925

7. AGE Years 4 Months 5 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ida

PARENTS

10. NAME OF FATHER Edward Welch

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary Meeks

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wyo

14. Informant Edwaed Welch
(Address) Orofino

15. Filed 7/11, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1929, to July 9, 1929 that I last saw him alive on July 9, 1929 and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:
Contusion and laceration of brain - Automobile Accident

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Cord tapped

(Signed) R. T. Hopkins, M. D.

July 10, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Orofino Ida — Date of Burial 7/12 - 1929

20. Undertaker W. A. Shaw — Address Orofino

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66928

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 72

183

2. FULL NAME Ira Robert Spencer

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 7th 1897

7. AGE Years 32 Months Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer) C.T.P.A.
(c) Name of employer C.T.P.A.

9. BIRTHPLACE (city or town) (State or country) Winchester Ky.

PARENTS
10. NAME OF FATHER Hiram Spencer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky
12. MAIDEN NAME OF MOTHER Dora Baker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ky.

14. Informant E. R. Chambers
(Address) Ahsahka

15. Filed 7/8, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4, 1929, to July 5, 1929
that I last saw him alive on July 5, 1929
and that death occurred, on the date stated above, at 7:00 am.
The CAUSE OF DEATH* was as follows:
Accidental Gunshot Wound of left leg - (infected)
..... (duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary) Bacillus Aerogenes Capsulatus infection of Wound (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of July 4
Was there an autopsy? no
What test confirmed diagnosis? Laboratory and Clinical findings
(Signed) O M Husted, M. D.
7/8, 1929 (Address) Orofino Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wells Bu... Date of Burial July 7 1929

20. Undertaker W. D. Pinson Address Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66929

PLACE OF DEATH
County of Clearwater
City of Weippe

Registration District No. 9
Primary Registration District No. 2197
Local Registrar's No. 71

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

20-A

2. FULL NAME Abel White

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced. HUSBAND of (or) WIFE of: E White

6. DATE OF BIRTH (month, day and year): Feeb. 10th 1865

7. AGE — Years: 64 | Months: 4 | Days: 24 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Grey Fork W. Va.

PARENTS

10. NAME OF FATHER: Joseph White
11. BIRTHPLACE OF FATHER (city or town) (State or Country): W. Va
12. MAIDEN NAME OF MOTHER: Susan Helmick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): W. Va

14. Informant: Mrs Elizabeth White
(Address): Weippe Ida

15. Filed 7/5-, 1929. H. A. Shaver Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

No Doctor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Elizabeth White, M.D.
7/4, 1929 (Address) wife

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Weippe	7/5- 1929
20. Undertaker	Address
W. D. Pinson	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66930

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 70
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Benda 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Benda

6. DATE OF BIRTH (month, day and year) 1848

7. AGE: Years 81 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS
10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bohemia
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bohemia

14. Informant Joe Svoboda
(Address) Orofino Ida

15. Filed 7/5, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from one visit, 19..., to May 23rd, 1929
that I last saw him alive on May 23, 1929
and that death occurred, on the date stated above, at 129 m.
The CAUSE OF DEATH* was as follows: Valvular Lesion

Dont Know (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Brights disease Dont Know (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no uninstant
What test confirmed diagnosis? Symptoms - Dropsy
(Signed) J. H. Robertson, M. D.
7/4, 1929 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino | Date of Burial: 7/5 1929

20. Undertaker: W. D. Pearson | Address: Orofino Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66931

PLACE OF DEATH
County of Clark
City of Dubois

Registration District No. 125
Primary Registration District No. 2203

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

170

2. FULL NAME Isabel Roman

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 5 1907

7. AGE: 22 Years | Months 8 | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Section Laborer
(c) Name of employer: Oregon Short Line RR

9. BIRTHPLACE (city or town) (State or country): Mexico

PARENTS

10. NAME OF FATHER: Albino Roman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mexico
12. MAIDEN NAME OF MOTHER: Alejandra Romero
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mexico

14. Informant: Maurice Alvarado
(Address): Dubois Idaho

15. Filed July 4, 1929 C E Jones MD
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ , 19 , to 19
that I ~~last saw h alive on~~ , 19
and that death occurred, on the date stated above, at about 10; 30 a m.

The CAUSE OF DEATH* was as follows:

Pistol shot in head
Suicide (probably)
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C E Jones, M. D.
July 4, 1929 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Dubois Idaho
Date of Burial: July 6. 1929

20. Undertaker: Cliff C Hays
Address: Idaho Falls Idaho

RECEIVED AUG 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66932

PLACE OF DEATH
County of Custer
City of Challis
Registration District No. 108
Primary Registration District No. 2186
Local Registrar's No. 91
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Robinson 101a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1841

7. AGE Years	Months	Days	If LESS than 1 day,
88			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) London England
(State or country)

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) London
(State or Country)
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) London
(State or Country)

14. Informant Ed C Solomon
(Address) Challis Idaho

15. Filed June 29, 1929 Edna McKenney
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to June 25, 1929
that I last saw him alive on June 25, 1929
and that death occurred, on the date stated above, at 8 a m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

6 (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic bronchitis
(duration) years yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) C. S. Kirby M. D.
7/6, 1929 (Address) Challis, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Challis, Ida	June 27 1929
20. Undertaker	**Address**
Thos Garnier	Mackay Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66934

PLACE OF DEATH
County of Custer
City of Challis

Registration District No. 108
Primary Registration District No. 2186
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 92

90

2. FULL NAME William Wallace Mavity
(a) Residence. No. Challis, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mable Bessie Mavity

6. DATE OF BIRTH (month, day and year) July 20, 1893

7. AGE: Years 35, Months 11, Days 21; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work merchandising
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer X

9. BIRTHPLACE (city or town) (State or country) Bayhorse, Idaho

PARENTS
10. NAME OF FATHER James Mavity
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Louise D. Workman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs. M. B. Chivers.
(Address) Challis. Idaho.

15. Filed July 14, 1929 Edna McKenney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July ~~13~~ 11 1929, to July ~~13~~ 11 1929
that I last saw him alive on July ~~13~~ 11, 1929
and that death occurred, on the date stated above, at 10:30 P.m.
The CAUSE OF DEATH* was as follows:
I did not see deceased until five minutes before death
Probably coronary artery disease
do not know (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) do not know
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) C. L. Kirtley, M. D.
7/13, 1929 (Address) Challis Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Challis, Idaho
Date of Burial: July 14 1929

20. Undertaker: Theo. R. Garnin
Address: Mackay, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 23 1931

C. L. KIRTLEY, M.D.

Challis, Idaho

April 16, 1931

Bureau of Vital Statistics
State of Idaho
State Capitol Building
Boise, Idaho

Attention: Miss Retta F. Martin, Registrar

Re: William W. Mavity
Deceased

Dear Madam:

At the insistent request of the widow of the above named deceased World War veteran and also other parties at interest, I am submitting additional medical data to become a part of your official records pertaining to the death of Mr. Mavity. My first report, which has been made of record in your office, did not contain the full information and was in error as to the cause of death. The facts of the death are as follows:

On July 11, 1929 I was called to his home and upon examination I could get no sound of the heart beat with a stethescope. He gasped a few times and was dead. The death undoubtedly was caused by an embolism from a rectal abscess lodged in the heart. There was history of hemorrhoids and rectal trouble existing for several years prior to his death.

Please file this for record.

Yours very truly,

C. L. Kirtley M.D.

C. L. Kirtley, M.D.

Subscribed and sworn to before me this 16th day of April, 1931

Emmett Donahue Co. Recorder
By John Boyd, Dept.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66935

PLACE OF DEATH

County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

183

2. FULL NAME Harold LeRoy Hulse

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Apr 27 1913

7. AGE: Years 16, Months 2, Days 10. If LESS than 1 day hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Rigby Idaho

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ephriam LeRoy Hulse

12. MAIDEN NAME OF MOTHER: Preston Idaho

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Effie Probert

14. Informant: Springville Utah Ephriam LeRoy Hulse
(Address) Dayton Idaho

15. Filed July 10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27, 1929, to Jul 8, 1929 that I last saw him alive on Jul 8, 1929 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows: General Systemic Infection following Gunshot wound of foot (Welsher Bacillus)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Horley, M. D.
Jul 9, 1929 (Address) Preston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby Idaho
Date of Burial: July 10 1929

20. Undertaker: M. W. Hendricks
Address: Preston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66936

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

129

2. FULL NAME Adelbert Maroni Cazier

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mabel Cazier

6. DATE OF BIRTH (month, day and year): July 9 1886

7. AGE: Years 43 Months 1 Days 7 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Trucking
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ogden Utah

PARENTS

10. NAME OF FATHER: Fredric Cazier
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ogden Utah
12. MAIDEN NAME OF MOTHER: Emma Campbell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ogden Utah

14. Informant: Mabel Cazier
(Address): Preston Idaho

15. Filed July 18, 1929 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-10, 1929, to 7-15, 1929
that I last saw him alive on 7-14, 1929
and that death occurred, on the date stated above, at 8 30 a m.
The CAUSE OF DEATH* was as follows:
Oedema of Lungs
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Chronic interstitial Nephritis
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Urinalysis
(Signed) E S Mulford, M. D.
7/15, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho
Date of Burial: July 18 1929

20. Undertaker: M. W. Hendricks
Address: Preston Idaho

RECEIVED AUG 7 1929

PLACE OF DEATH

County of Franklin

City of Preston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. 161a)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 66937

Local Registrar's No.

2. FULL NAME Ruth Sherley Shrives

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. If Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): July 15 29

7. AGE: Years | Months | Days | If LESS than 1 day, 0 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Preston Idaho

PARENTS

10. NAME OF FATHER: Frank Shrives

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Ruth Anderson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Weston Idaho

14. Informant: Frank Shrives
(Address): Weston Idaho

15. Filed July 17, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-15, 1929, to 7-15, 1929
that I last saw h[illegible] alive on 7-15, 1929
and that death occurred, on the date stated above, at 7 A.M. p.m.
The CAUSE OF DEATH* was as follows:
Premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Placenta Previa

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) E S Mulford, M. D.
7-17, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Franklin Idaho	July 17 29
20. Undertaker	Address
M. W. Hendricks	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66938

PLACE OF DEATH
County of Franklin
City of Franklin

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucy Baker

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Benjiman Charles Baker

6. DATE OF BIRTH (month, day and year) June 13 1865

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62		22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) South Wales

PARENTS

10. NAME OF FATHER John D. Evans

11. BIRTHPLACE OF FATHER (city or town) (State or Country) S Wales

12. MAIDEN NAME OF MOTHER Marguret Harris

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) South Wales

14. Informant Charles Baker
(Address) Franklin Idaho

15. Filed July 7, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3, 1929, to July 5, 1929, that I last saw her alive on July 3, 1929, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:
Carcinoma. Nasal & Gastric

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetis Mellitis

(duration) unknown yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Benedicts

(Signed) E. S. Mulford M. D.
7/6, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Franklin Idaho — Date of Burial: July 7 1929

20. Undertaker: M.W. Hendricks — Address: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66939

PLACE OF DEATH

County of Franklin

City of Riverdale

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hyrum Smith

74a

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Elvira Smith

6. DATE OF BIRTH (month, day and year): Oct. 31 1847

7. AGE: Years 81, Months 8, Days 15. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED: Farmer

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: Samuel Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Lions

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Samuell Smith
(Address): Riverdale Idaho

15. Filed July 17, 1929 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-21, 1929, to 7-4, 1929 that I last saw him alive on 5-5 1929 and that death occurred, on the date stated above, at 3:00 a.m.

The CAUSE OF DEATH* was as follows:

Coronary Ex
Chronic interstitial
nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. R. Cutler, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverdale Idaho
Date of Burial: July 17 1929

20. Undertaker: M. W. Hendricks
Address: Preston Idaho

RECEIVED AUG 7 1929

PLACE OF DEATH

County of Franklin

City of Preston Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 27

Primary Registration District No. 2119

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66940

Local Registrar's No.

2. FULL NAME Andrew Ipson

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Dorthea Ipson

6. DATE OF BIRTH (month, day and year) Nov. 13 1842

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Jeppe Thompson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Metta Thompson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Kyrum Ipson

(Address) Glenns Ferry

15. Filed July 12, 1929 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 8 1929

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Not determined

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. R. Cutler, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mink Creek Ida	June 1929
20. Undertaker	**Address**
M. W. Hendricks	Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66941

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minnie Eva Peters

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): M
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Raymond
6. DATE OF BIRTH (month, day and year): July 21 1884
7. AGE: Years 44 | Months 11 | Days 29 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED: Housewife
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Clifton Idaho

PARENTS
10. NAME OF FATHER: Peter Larsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Wilhelmina Larsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweeden

14. Informant: Ray Peters
(Address): Clifton Idaho
15. Filed July 23, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 16, 1929, to July 20, 1929
that I last saw her alive on July 20, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Surgical Shock
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. R. Curtis, M. D.
7-22, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clifton Idaho	July 23 1929

20. Undertaker: M.W. Hendricks — Address: Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66942

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No. 484)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Philip Armond Paull

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male | 4. COLOR OR RACE: White | 5. If Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 22 22

7. AGE: Years 6 | Months 9 | Days 26 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED: Baby
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Preston Idaho

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Geo Paull

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Battlecreek Idaho

12. MAIDEN NAME OF MOTHER Lettie Busbie

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Blogan Utah

14. Informant Geo Paull
(Address) preston Idaho

15. Filed 7-23, 1929 C. R. Cutler Registrar M. W. Hendricks

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-1, 1929, to 7-20, 1929, that I last saw h[illegible] alive on 7-19, 1929 and that death occurred, on the date stated above, at 12-10 a.m.

The CAUSE OF DEATH* was as follows:
Acute Endocarditis
Acute Endocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. R. Cutler, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Logan Utah 7 | Date of Burial: 22 19

20. Undertaker: | Address:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66943

PLACE OF DEATH
County of Fremont
City of Teton

Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 282
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Agnes Hughes
(a) Residence. No. Teton Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Henry Hughes.

6. DATE OF BIRTH (month, day and year) Feb 27-1851

7. AGE: Years 78 | Months — | Days 13 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): England.

PARENTS
10. NAME OF FATHER: James Gordner
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Hannah
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Agnes Ellen Roberts
(Address) Teton Idaho

15. Filed Mar. 13, 1929 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March. (Month) 12th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 2nd, 1929, to Mar. 12th, 1929 that I last saw her alive on Mar. 10, 1929 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows: High Blood Pressure

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Hemorrhage-Nasal

..... (duration) ..... yrs. 1 mos. ..... ds.

18. Where was disease contracted if not at place of death? no

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? History

(Signed) P. Wellhall, M. D.

Mar. 12, 1929 (Address) St. Anthony Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Teton | Date of Burial: Mar. 15 1929

20. Undertaker: W. M. Hansen | Address: St. Anthony Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66944

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 281

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

151

2. FULL NAME Hulda Gaw

(a) Residence. No. Chester Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles Gaw

6. DATE OF BIRTH (month, day and year) Dec 21-1880

7. AGE Years 49 Months 2 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pleasant View Utah

PARENTS

10. NAME OF FATHER Thomas J. Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Louma Clifford
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Thomas J. Brown
(Address) Chester Idaho

15. Filed 3/8, 1929 W M Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 7th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 5th, 1929 to Mar. 7th, 1929
that I last saw her alive on Mar. 5th, 1929
and that death occurred, on the date stated above, at 9 A. m.
The CAUSE OF DEATH* was as follows:
Gangrene of Arm.
..... (duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary) Chr. Rheumatism
..... (duration) 4 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Mar. 6-29
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) P. M. Kelley, M. D.
3-7-, 1929 (Address) St. Anthony, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wilford | Date of Burial Mar 9 1929

20. Undertaker W. M. Hansen | Address St. Anthony Ida

MARGIN RESERVED FO

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19

RECEIVED AUG 9 1929

1. PLACE OF DEATH

County of Fremont

City of Hamer

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 99

Primary Registration District No. 2177

(No. ..... St.)

2. FULL NAME William Erickson

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66945

Local Registrar's No. 280

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH: Nov. (Month) 3 (Day) 1880 (Year)

7. AGE: 48 Yrs. 2 Mos. 25 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Odgen Utah.

10. NAME OF Father: John Erickson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Hannah Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Erickson
(Address): Lewisville Idaho

15. Filed Feb. 26th 1929 W. M. Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 25th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1929, to Feb. 23rd 1929 that I last saw him alive on Feb. 23rd 1929 and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis
Kelly

(Duration) ..... yrs. 3 mos. ..... ds.

Contributory (Secondary) Chr. Myocarditis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) J. M. Kelly M. D.

2-25 1929 (Address) St. Anthony, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker — DATE OF BURIAL: Feb. 27th 1929

20. UNDERTAKER: W. M. Hansen — ADDRESS: St. Anthony Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66946

PLACE OF DEATH
County of Fremont
City of St. Anthony

Registration District No. 99
Primary Registration District No. 2177

Local Registrar's No. 279

(No. 129) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Elizabeth Mikesell

(a) Residence. No. St. Anthony Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred: yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Feb 23 1929
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of John C. Mikesell

6. DATE OF BIRTH (month, day and year) Dec. 9th 1844

7. AGE	Years	Months	Days	If LESS than 1 day,
	84	2	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) John C. Mikesell
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER John C. Mikesell Sr.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) America

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Andrew Mikesell
(Address) St. Anthony

15. Filed Feb. 28, 1929 A.W. Hansen
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 23rd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1929, to Feb. 23, 1929, that I last saw her alive on Feb. 20th, 1929, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Kelly
(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History & urine

(Signed) O. M. Kelly, M. D.
2-23-, 1929 (Address) St. Anthony, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Idaho	Feb. 25 1929

20. Undertaker	Address
F. M. Hansen	St. Anthony

FORM V. S. No. 5-25 M. 1-19

RECEIVED AUG 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 6694
Local Registrar's No. 278

1. PLACE OF DEATH

County of Fremont
City of St. Anthony
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2177
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret McAlpine Kooch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Apr. 25 (Month) (Day) 1868 (Year)

7. AGE: 60 Yrs. 10 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF Father: Alfred McAlpine

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J A Ellison
(Address) .....

15. Filed Feb 20 1929 W M Hansen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 8 1929. to Feb. 19 ....,
that I last saw her alive on Feb 20 1929,
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Hemorrhage from stomach following vomiting due to tenacious mucus in throat.
(Duration) ..... yrs. ..... mos. 12 ds.
Contributory (Secondary) Empiema
(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) J A Ellison M. D.
7-22-1929 (Address) St. Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St. Anthony Idaho
DATE OF BURIAL: Feb 22 1929

20. UNDERTAKER: W. M. Hansen
ADDRESS: St. Anthony Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66948

PLACE OF DEATH
County of Fremont
City of Parker

Registration District No. 99
Primary Registration District No. 2177
(No.)

Local Registrar's No. 277

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Elizabeth Mary Larson

(a) Residence. No. 131 St. Parker, Ida.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86 1842	Sept.	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): England

PARENTS
10 NAME OF FATHER: Geo. S. Fox
11 BIRTHPLACE OF FATHER (city or town) (State or country): England
12 MAIDEN NAME OF MOTHER: Betsy Jones
13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Edward Larsen (Son)
(Address) St. Anthony, Idaho.

15 Filed Feb 16, 1929 C. W. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. (Month) 15 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1929, to Feb. 15, 1929, that I last saw her alive on Feb. 13, 1929, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:
Acute Brights.
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) High Blood Pressure + Cholecystitis
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Findings
(Signed) P. M. Kellogg, M. D.
2-15-1929 (Address) St. Anthony, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Parker	Feb 17 1929

20. Undertaker: W. M. Hansen Address: St. Anthony

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66949

PLACE OF DEATH
County of Fremont Registration District No. 77
City of Twin Groves Primary Registration District No. 2177
(No.) Local Registrar's No. 276
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mabell Ann Lewis

(a) Residence. No. 101a St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Infant

6 DATE OF BIRTH (month, day and year)

7 AGE: Years | Months | Days 22 22 | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Twin Groves Ida

PARENTS

10 NAME OF FATHER: Lafay Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond, Utah

12 MAIDEN NAME OF MOTHER: Mabel Clair Edgington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Twin Groves Ida

14 Informant: Lafay Lewis
(Address): Twin Groves, Ida

15 Filed Jan 29, 1929 Wm Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan. (Month) 29, (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1929, to Jan. 29, 1929
that I last saw her alive on Jan. 28, 1929
and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Infant
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) J. M. Reed, M. D.
1-29-1929 (Address) St Anthony Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Milford — Date of Burial: Feb 1 1929
20. Undertaker: Kime — Address:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66050

PLACE OF DEATH
County of Fremont
City of St. Anthony

Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 275

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David Marion Munro

(a) Residence. No. Chester Idaho St. ....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Sarah Munro

6. DATE OF BIRTH (month, day and year) May 22 - 1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	60	8	5	....hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer ....

9. BIRTHPLACE (city or town) (State or country) Spanish Fork Utah

PARENTS

10. NAME OF FATHER William Munro
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Emily M. Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mass.

14. Informant Mrs Sarah Munro
(Address) St. Anthony Idaho

15. Filed Jan. 28, 1929 Lora Stanner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 27th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1st, 1926 to Jan. 27th, 1929
that I last saw him alive on Jan. 26th, 1929
and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach
Dr Kelley
(duration) 1 yrs. 10 mos. ....ds.

CONTRIBUTORY (Secondary) ....
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? Yes Date of Jan. 1929
Was there an autopsy? Yes
What test confirmed diagnosis? Oper. finding.
(Signed) P. M. Kelley M. D.
Jan 27, 1929 (Address) St. Anthony Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Anthony Idaho	Jan 31 1929

20. Undertaker N. M. Hansen Address St. Anthony Ida

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66951

PLACE OF DEATH
County of Fremont
City of St Anthony

Registration District No. 99
Primary Registration District No. 2177

Local Registrar's No. 274

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Marion Holbrook

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Oct 12-1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) St. anthony Ida
(State or country) 1928 12. th octobr

PARENTS

10. NAME OF FATHER Robert R Holbrook
11. BIRTHPLACE OF FATHER (city or town) parker
(State or Country) Idaho
1900 24 of May
12. MAIDEN NAME OF MOTHER Eva Hazel Garver
13. BIRTHPLACE OF MOTHER (city or town) Mrs Robert Holbrook
(State or Country) St anthony Ida. 1905

14. Informant Robert R. Holbrook
(Address) St Anthony Idaho

15. Filed Jan 31, 1929 W.W. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 20th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1929 to Jan. 20, 1929
that I last saw him alive on Jan. 20, 1929
and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:
Suffocation (accidental)
(duration) yrs. mos. 1 hr.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no (Examination)
What test confirmed diagnosis? History + findings
(Signed) O. M. Kelly M. D.
1-20-, 1929 (Address) St Anthony, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rohlins	Jan 22 1929

20. Undertaker W.W. Hansen Address St. Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

PLACE OF DEATH

County of Fremont

City of St. Anthony

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 99

Primary Registration District No. 2177

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66954

Local Registrar's No. 294

2. FULL NAME Frankie Elizabeth Hathaway

(a) Residence. No. St. Anthony Idaho St. 188 C
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
~~HUSBAND of~~
~~(or) WIFE of~~

6. DATE OF BIRTH (month, day and year) April 28-1913

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
16	1	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chester Idaho

PARENTS

10. NAME OF FATHER Charles W. Hathaway

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Chester Idaho.

12. MAIDEN NAME OF MOTHER Josephine Russell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rigby Idaho

14. Informant Mrs Josephine R. Hathaway

(Address) St. Anthony Idaho

15. Filed June 16th, 1929 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 15th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to June 15, 1929 that I last saw her alive on June 15, 1929 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Cutting of throat by glass accidental & auto accident.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Saw condition

(Signed) P. M. Kelly, M. D.

6-15-, 1929 (Address) St. Anthony, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Parker Idaho

Date of Burial: June 17 1929

20. Undertaker: W M Hansen

Address: St. Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66957

PLACE OF DEATH
County of Fremont
City of St. Anthony Idaho
Registration District No. 97
Primary Registration District No. 2177
Local Registrar's No. 291

(No. 187)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Phillip Braksmaw

(a) Residence. No. St. Anthony Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Lucian Braksmaw

6. DATE OF BIRTH (month, day and year) June 26 1903

7. AGE	Years	Months	Days	If LESS than 1 day,
	76	—	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Phillip Schmidis

9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10. NAME OF FATHER Phillip Braksmaw
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Mary Walker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant Phillip Schmidis
(Address) St. Anthony Idaho R. F. D. #3

15. Filed July 22, 1929 Conrad Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. M. Hansen, M. D.
July 24, 1929 (Address) St. Anthony

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parker	July 24 1929

20. Undertaker W. M. Hansen Address St. Anthony Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66958

PLACE OF DEATH
County of Fremont
City of St. Anthony

Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 290

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Julia Ann Kershaw

(a) Residence. No. St. Anthony Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph H. W. Kershaw

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 67, Months 10, Days 21. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Salt Lake City Utah

PARENTS

10. NAME OF FATHER: Alfred Clift
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Maria Moss
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Joseph H. W. Kershaw
(Address) St. Anthony Idaho

15. Filed June 27, 1929 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 26th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1929, to June 26th, 1929 that I last saw her alive on June 25th, 1929 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Bowel

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Tumor & obstruction
(Signed) P. M. Kelly, M. D.
6-26-, 1929 (Address) St. Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wilford — Date of Burial: June 28 1929

20. Undertaker: W. M. Hansen — Address: St. Anthony Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66959

PLACE OF DEATH
County of Fremont
City of St. Anthony

Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 289

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Pont

(a) Residence. No. St. Anthony Idaho St. 48a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Catherine Pont

6. DATE OF BIRTH (month, day and year) Feb. 14-1848

7. AGE: Years 81 | Months 4 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Neath Glamorganshire Wales England

PARENTS

10. NAME OF FATHER Wm Pont

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant John Pont
(Address) Rexburg Idaho

15. Filed June 18, 1929 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15th, 1929, to June 17, 1929
that I last saw him alive on June 14, 1929
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows: Chronic Cystitis
(duration) yrs. 8 mos. ds.
CONTRIBUTORY (Secondary) Endocarditis
(duration) 1 yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Findings
(Signed) P. M. Kelly, M. D.
June 17-1929 (Address) St Anthony, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Parker Idaho | Date of Burial: June 20 1929

20. Undertaker: W M Hansen | Address: St Anthony Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66960

PLACE OF DEATH
County of Fremont
City of St Anthony

Registration District No. 99
Primary Registration District No. 2177
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 288

2. FULL NAME James Medad Thompson 74a

(a) Residence. No. St. Anthony Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elizabeth Thompson

6. DATE OF BIRTH (month, day and year) April 21-1863

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	1	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mason
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hooper Utah.

PARENTS

10. NAME OF FATHER Edmund H. Thompson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~~Penn~~ Mich
12. MAIDEN NAME OF MOTHER Francis R. Wellborn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant John E. Thompson
(Address) Edna Wyo.

15. Filed May 29, 1929 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 26th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26, 1929 to May 26, 1929 that I last saw him ~~alive~~ dead on May 26, 1929 and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows:
Apoplexy
Kelly
..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? History
(Signed) P. M. Kelly, M. D.
May 26, 1929 (Address) St. Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wilford
Date of Burial: May 29 1929

20. Undertaker: W. M. Hansen
Address: St. Anthony Ida

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66961

PLACE OF DEATH
County of Fremont
City of St. Anthony

Registration District No. 99
Primary Registration District No. 2177

Local Registrar's No. 287

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Ralph Richards

(a) Residence. No. St. Anthony Idaho St. 748
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Selina Richards

6. DATE OF BIRTH (month, day and year) Nov 10th 1870

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Thomas Richards
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Adelaide Richards
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Ralph Richards
(Address) St. Anthony Idaho Route 2

15. Filed May 12, 1929 Wm M Hanson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 11th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1929 to May 11th 1929
that I last saw him alive on May 10, 1929
and that death occurred, on the date stated above, at 7 a. m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? History

(Signed) P. M. Kelly, M. D.
5-11-, 1929 (Address) St. Anthony, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Teton Idaho	May 13 1929
20. Undertaker	Address
W. M. Hanson	St. Anthony Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66962

PLACE OF DEATH
County of Fremont
City of St Anthony

Registration District No. 99
Primary Registration District No. 2177
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 286

31

2. FULL NAME Fred Colman
(a) Residence. No. St Anthony Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E Colman

6. DATE OF BIRTH (month, day and year)

7. AGE 67 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Taxidermist
(b) General nature of industry, business, or establishment in which employed (or employer) Employer
(c) Name of employer Fred Colman

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS
10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " " Dont Know
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Anna E Colman
(Address)

15. Filed May 8, 1929 W M Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 8th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1928, to 5-8, 1929
that I last saw h~~e~~ alive on 5-8-, 1929
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Flue in October 28
10 days (duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? no
What test confirmed diagnosis? Microscopical
(Signed) W. B. Wist, M. D.
5 10, 1929 (Address) St Anthony

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation~~, or Removal Michigan | Date of Burial 19

20. Undertaker W. M. Hansen | Address St Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66963

PLACE OF DEATH

County of Fremont
City of Saint Anthony

Registration District No. 19
Primary Registration District No. 2177
Local Registrar's No. 285

(No. 105 East 3rd, North (Residence))
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harrison Doud Brainard

(a) Residence. No. 105 East 3rd North St. 101a
(Usual place of abode)
Length of residence in city or town where death occurred. 28 yrs. 11 mos. xx ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~[illegible]~~ Ida L. Brainard

6. DATE OF BIRTH (month, day and year) Dec. 20, 1855

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	3	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None last two years

9. BIRTHPLACE (city or town) (State or country) Burlington, Wis.

PARENTS

10. NAME OF FATHER Elmer Brainard

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant [illegible]
(Address)

15. Filed Apr 11, 1929 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1929, to Apr. 11, 1929
that I last saw him alive on Apr. 11, 1929
and that death occurred, on the date stated above, at 3 p.m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Chr. Myocarditis & Endocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible], M. D.
Apr. 15, 1929 (Address) St. Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Anthony Ida	Apr. 13 1929
20. Undertaker	Address
W. M. Hansen	St. Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66964

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 99
Primary Registration District No. 2177
(No.)
Local Registrar's No. 284
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rosie Mabie Earl

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 5th 1927

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11	28.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Brookland N. Y.

PARENTS

10. NAME OF FATHER Eugene Earl.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Plymouth Utah
12. MAIDEN NAME OF MOTHER Ester Maria Thompson.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Ester Maria T. Earl.
(Address) Parker Idaho

15. Filed Apr. 7 1929 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1929, to Apr. 3, 1929
that I last saw h[illegible] alive on Apr. 3, 1929
and that death occurred, on the date stated above, at about 10 p.m.
The CAUSE OF DEATH* was as follows:
Laryngeal Diphtheria
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. A. Ellison, M. D.
Apr. 4, 1929 (Address) St. Anthony Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parker	Apr. 4th 1929
20. Undertaker	Address
None	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66965

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 283

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rule Dean Millward

(a) Residence. No. St. Anthony Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 5 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Anthony Idaho

PARENTS
10. NAME OF FATHER Rodger E. Millward
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Grantsville Utah
12. MAIDEN NAME OF MOTHER Margaret Clark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Teton Idaho

14. Informant Rodger E. Millward
(Address) St. Anthony Idaho

15. Filed 3/16, 1929 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 16th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. B. West, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Teton | Date of Burial: March 18 1929

20. Undertaker: W. M. Hansen | Address: St. Anthony Idaho

FORM V. S. No. 5-25 M. RECEIVED JUL 26 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66967

Local Registrar's No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Gooding

City of Wendell

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 18

(No. ..... St.)

2. FULL NAME Maurice E. Huff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Divorced

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1876 (Year)

7. AGE: 53 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Construction Foreman

(b) General nature of industry, business or establishment in which employed (or employer): Idaho Power Co.

9. BIRTHPLACE (State or Country): Topsfield Maine.

10. NAME OF Father: Justin E, Huff

11. BIRTHPLACE OF FATHER (State or Country): Topsfield. Maine

12. MAIDEN NAME OF MOTHER: Sarrah Kneleind.

13. BIRTHPLACE OF MOTHER (State or Country): Topsfield . Maine.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertha Mallory.

(Address) Leadore Idaho

15. Filed 6th /26th /29 19 E. L. Simmons Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 24th (Day) 1929 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 24th 19 , to June 24th-1929 , that I last saw him alive on June 24th-1929 19 , and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Angina Pectoria

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Zeller M. D.

19 29 (Address) Jerome, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 15 days. In the State 15 yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Olympia. Wash.

DATE OF BURIAL: June 28 1929

UNDERTAKER: D.L. Herrisson.

ADDRESS: Jerome. Ida ho

FORM V. S. No. 5-25 RECEIVED JUL 26 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Gooding
City of Wendell
If death occurred away from usual residence, give facts called for under special information.

Registration District No. 20
Primary Registration District No. 2015
(No. ..... St.)

File No. 66968
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marion Estep

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Married~~ Single

6. DATE OF BIRTH: July (Month) 15 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: v
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wendell Idaho

10. NAME OF FATHER: John L. Estep

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Hattie A. Kaenig

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hattie Estep
(Address) Wendell Ida

15. Filed July 23 1929 E R Simanton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1929 to July 16 1929
that I last saw h.er alive on July 16 1929,
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
.....
.....
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. R. Simanton M. D.
7-23 1929 (Address) Wendell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wendell Ida — DATE OF BURIAL: 7-28 1929

20. UNDERTAKER: None — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 26 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Gooding
City of Wendell
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 22
Primary Registration District No. 2018
(No. ..... St.)

File No. 66069
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Jefferson Gates

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH: May (Month) 11 (Day) 1854 (Year)

7. AGE: 75 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Warbash Ind

10. NAME OF FATHER: Thomas Gates

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Della Gates
(Address) Wendell Ida

15. Filed May 10 1929 E. L. Simonton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1929 to May 10 1929
that I last saw h. im alive on May 1 1929
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach and liver.
(Duration) Yrs. 6 mos. — ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E. L. Simonton M. D.
5-10 1929 (Address) Wendell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wendell Ida — DATE OF BURIAL: 5-12 1929
UNDERTAKER: Geo Smith — ADDRESS: Wendell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 1 REVISED

RECEIVED AUG 7 1929

CERTIFICATE OF DEATH

Registration District No. 24

Primary Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66979

Registered No. 101

1. PLACE OF DEATH

County of Gooding

City of Gooding

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emely E Hoodenpyle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH

Aug. (Month) 25 (Day) 1863 (Year)

7. AGE

65 Yrs. 10 Mos. 15 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER G. Sims Howell

11. BIRTHPLACE OF FATHER (State or Country) N. C.

12. MAIDEN NAME OF MOTHER Elizabeth Hodges

13. BIRTHPLACE OF MOTHER (State or Country) Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. O. Hoodenpyle

(Address)

15. Filed 7-31-1929 J H Cranwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7 (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 10 1929 to July 9 1929 that I last saw h alive on July 9 1929 and that death occurred on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH* was as follows:

Hepatic Carcinoma

(Duration) 1 Yrs. 1 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Houston E Snyder M. D.

7-11 1929 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66971

PLACE OF DEATH
County of Gooding
City of Gooding
Registration District No. 24
Primary Registration District No.
Local Registrar's No. 103
(No. Gooding County Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Ura

(a) Residence. No. Shoshone Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Japanese	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1877

7. AGE	Years	Months	Days	If LESS than 1 day,
	52			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Restaurant Employee
(b) General nature of industry, business, or establishment in which employed (or employer) Has not worked for
(c) Name of employer 2 years.

9. BIRTHPLACE (city or town) (State or country) Japan

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Japan

14. Informant E. M. Tanaka
(Address)

15. Filed 7-31-, 1929. J. H. Curwell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26, 1929, to July 30, 1929
that I last saw him alive on July 30, 1929
and that death occurred, on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Alcoholism
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of
Was there an autopsy? no
What test confirmed diagnosis? Phy. Exam.
(Signed) T. E. Hazzit, M. D.
July 31, 1929 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shoshone Idaho	8-1 1929
20. Undertaker	**Address**
C. C. Pickok	Shoshone Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 7 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66972

County of .....
City of .....
Registration District No. 24
Primary Registration District No. 24a
Local Registrar's No. 102
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mrs Mary E Mattson

(a) Residence. No. ..... St. Gooding Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years 56 Months — Days 6 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10 NAME OF FATHER Jonas Oslund
11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden
12 MAIDEN NAME OF MOTHER Don't Know
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant M Mattson
(Address) Gooding Ida

15 Filed ....., 19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 13 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1928, to July 13, 1929
that I last saw her alive on 7-13-, 1928
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage (apoplexy)
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Linkemia
(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J H Cromwell M. D.
7/13, 1929 (Address) Gooding

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Gooding
Date of Burial 7-15 1929

20. Undertaker A E Thompson
Address Gooding

RECEIVED JUL 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66973

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
Local Registrar's No. 277

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Willis Henry Yingst 142

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 28, 1896

7. AGE

Years	Months	Days	If LESS than 1 day,
33	2	27	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS

10. NAME OF FATHER Winfield Scott Yingst
11. BIRTHPLACE OF FATHER (city or town) (State or Country) not-oblamable
12. MAIDEN NAME OF MOTHER Martha Phillips
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas

14. Informant W. E. Smith
(Address) Kooskia . Idaho

15. Filed July 1, 1929 J M Verbeekmors Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
accidentally drowned crossing Clearwater River - near O-Hara creek
Body not recovered (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) J. M. Verbeekmors, M. D.
July 1, 1929 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 16 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Dr. J.M. Verberkmoes 66973

Kooskia, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

E. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

Willis Henry Yingst who died at Kooskia, Idaho on May 25, 1929

Information DESIRED in order to complete certificate.

The date of birth and the age.

PLEASE ANSWER BELOW

February - 28 - 1896
Age 33 yrs 2 mos - 27 days.

The above information was given to me by his brother in law - and he thinks it is correct -

Jos. Verberkmoes

FORM V. S. No. 5-A. 25 M. 1-19

RECEIVED AUG 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

Registration District No. ~~25~~ 103

Primary Registration District No. 2181

(No. McCall, Idaho St.)

File No. 6~~5~~974

Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Edna Haan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: August (Month) 5 (Day) 1882 (Year)

7. AGE: 47 Yrs. 11 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Peter Haan

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Susan Knoblock

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edgar Fry

(Address) Ferdinand, Idaho

15. Filed 7/17 1929 Dr. B. Chipman Local Registrar

Glenn Ailor Dept.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ examined body July 15 1929, to at 3:30 a.m. ~~19~~

that I ~~last~~ never saw her alive on 19

and that death occurred on the date stated above, at about 2:45 A.M. promptly regently earlier.

The CAUSE OF DEATH* was as follows:

(History of Epilepsy)

no indications of violence or of poisoning

(Duration) indefinite Yrs. ..... mos. ..... ds.

Contributory (Secondary) Heart lesion.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. S. Numbers M. D.

19 (Address) McCall, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow, Idaho

DATE OF BURIAL: 7/18/29 19

20. UNDERTAKER: Vassar

ADDRESS: Grangeville Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66975

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 2181
(No. At Home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 29

100 a

2. FULL NAME John (Jack) H. ~~Stephens~~ Stevens

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Letha Stevens

6. DATE OF BIRTH (month, day and year) Jan 16 1889

7. AGE Years 40 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Invalid.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden Utah

PARENTS

10. NAME OF FATHER John Stevens

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Minnie Hoath

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nevada

14. Informant Chas Stevens
(Address) Lewiston Idaho.

15. Filed 7/14, 1929 Dr. B. Chipman Glenn Allen Registrar Dept.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-13, 1929, to 7-14, 1929
that I last saw him alive on 7-17, 1929
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Progressive Bulbar Paralysis
..... (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. D. Shinnick M. D.
7-14, 1929 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho. Date of Burial July 16 1929

20. Undertaker Vassar McOlvary Address Lewiston

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66976

PLACE OF DEATH
County of Idaho
City of

Registration District No. 103
Primary Registration District No. 2181

Local Registrar's No. 28

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Wilbur Van Wey

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Van Wey

6. DATE OF BIRTH (month, day and year) ~~June~~ 16 1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) R
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS
10. NAME OF FATHER Jones Van Wey
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Jennie Van Wey (Address) White Bird Idaho

15. Filed 8-1- 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Accidental drowned in Salmon River near Whitebird Idaho.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Whitebird Ida.	July 14 1929
20. Undertaker	Address
Hunelock Mort. Co.	Grangeville Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66977

PLACE OF DEATH
County of Jefferson
City of Hamer

Registration District No. 98
Primary Registration District No. 2176
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 32

188 C

2. FULL NAME Martin D. Schlagel
(a) Residence. No. Hamer, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) February 14 1892

7. AGE Years 37 Months 4 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or ~~town~~) (State or country) Minnesota

PARENTS
10. NAME OF FATHER Winsted Schlagel
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minnesota
12. MAIDEN NAME OF MOTHER Mary Stifter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant F N Schlagel
(Address) Spokane Wa

15. Filed 7-1, 1929 H Gering M.D. By J Taylor Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——, 19..., to ——, 19...
that I last saw h ~~alive on~~ ——, 19...
and that death occurred, on the date stated above, at About 7 P. m.
The CAUSE OF DEATH* was as follows:
Automobile Accident
Instant (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Donna Carelessness
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ——
Did an operation precede death? —— Date of ——
Was there an autopsy? No
What test confirmed diagnosis? ——
(Signed) Ira J Taylor Coroner, M. D.
6/17, 1929 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Brainerd, Minnesota
Date of Burial June 20 1929

20. Undertaker Jack A. Wood
Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66978

PLACE OF DEATH

County of Jefferson
City of Lorenzo

CERTIFICATE OF DEATH

Registration District No. 98
Primary Registration District No. 2176
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 33

2. FULL NAME Mary (Reid) Murdockh

(a) Residence. No. ..... St. 133
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F. M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced ~~[illegible]~~ (or) WIFE of: Wm. Murdockh

6 DATE OF BIRTH (month, day and year): October 23rd 1851

7 AGE: Years 77 | Months 7 | Days 30 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10 NAME OF FATHER: James Reid.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Elizabeth Cummins.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Mrs. Hugh Davis
(Address) Chester, Idaho

15 Filed 7-1, 1929 C. H. Tavin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 22 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to June 21, 1929, that I last saw her alive on June 21, 1929, and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows: Empyema of gall bladder

..... (duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary): Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Ronn F. Rich M. D.

June 23, 1929 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Heber City, Utah

Date of Burial: 6/25/29 19

20. Undertaker: A B Eckersell

Address: Rigby

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66979

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 216

Local Registrar's No. 34

(No.) 47
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Neeltje Vanderwel.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Widowed.

5a. If married, widowed, or divorced
~~HUSBAND~~ (or) WIFE of John Vanderwel.

6. DATE OF BIRTH (month, day and year) Sept. 9th 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	9	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Holland.

PARENTS

10. NAME OF FATHER Leendert Barendregt.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holland
12. MAIDEN NAME OF MOTHER Willempje Vanderwiel.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Holland

14. Informant H. C. Vanderwel
(Address) Rigby, Idaho.

15. Filed 7-1, 1929 C. A. Raven Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to June 11th, 1929
that I last saw her alive on June 11th, 1929
and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Breast
with Intra Thoracic Metastases

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Rigby - Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Microscopic

(Signed) H. A. Anderson, M. D.
June 13, 1929 (Address) Rigby - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho.	6/13/29 19

20. Undertaker C. W. Eckersell Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66980

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No. 35

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leslie James Anderson.

(a) Residence. No. ..... St. 162
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Babe

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Babe

6. DATE OF BIRTH (month, day and year): Dec. 16 1927

7. AGE: Years 1, Months 17, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Babe
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Rigby, Idaho.

PARENTS

10. NAME OF FATHER: Francis Alma Anderson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Mary Marie Jakeman.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Francis Anderson
(Address) Rigby, Idaho.

15. Filed 7-1, 1929 C. H. Lavin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1929 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ On June 3d, 1929, ~~to~~ he was dead on my arrival, 19
that I last saw h..... alive on ....., 19
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Drowning
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): None
✓ (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. A. Anderson, M. D.
....., 19 (Address) Rigby - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby, Idaho. Date of Burial: 6/5/29 19

20. Undertaker: A B Eckersell Address: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66981

RECEIVED JUL 18 1929

PLACE OF DEATH

County of Jefferson
City of Rigby
Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No. 36
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Jesse West.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of [redacted] Elizabeth (Newman) West.

6. DATE OF BIRTH (month, day and year) Feb. 22, 1868

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	2	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Butcher Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Retail
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Salt Lake City.

PARENTS

10. NAME OF FATHER Charles West.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Eliza Dangerfield.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Elizabeth West.
(Address) Rigby, Idaho

15. Filed 7-1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to , 19
that I last saw h[redacted] alive on May 13, 1929
and that death occurred, on the date stated above, at 5 A. m.
The CAUSE OF DEATH* was as follows:
Chr. Myocarditis & Hypertension
Senile Pathology
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis & Diabetes
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) W. A. West, M. D.
May 14, 1929. (Address) Rigby, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho!	5/17/29 19

20. Undertaker [signature] Address Rigby

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 18 1929

Local 37

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jefferson

City of Rigby No III

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98

Primary Registration District No. 3176

(No. ..... St.)

File No. 66982

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helena Gustava L. Call

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: April (Month) 5 (Day) 1843 (Year)

7. AGE: 86 Yrs. 1 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Pierce Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Sarah Kajsa Glade

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ellis Call

(Address) Rigby Idaho

15. Filed 7-1 1929 C. H. Gaver Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 164

May (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) — Yrs. — mos. — ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. West M. D.

5/20 1929 (Address) Rigby Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 7 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Willard

19. PLACE OF BURIAL OR REMOVAL: Willard

DATE OF BURIAL: May 22 1929

20. UNDERTAKER: Intermountain Mort. Co. Ogden

ADDRESS: N. Malone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Jones.

RECEIVED JUL 18 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66983

County of Jefferson
City of Menan

Registration District No. 98
Primary Registration District No. 3176

Local Registrar's No. 38

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Lewis Jones.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

100a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed.

5a. If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mary (Brightwell) Jones.

6. DATE OF BIRTH (month, day and year) Dec. 3, 1847

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
81	5	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer: Self.

9. BIRTHPLACE (city or town) (State or country): West Virginia

PARENTS

10. NAME OF FATHER: Thomas Jones.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: --- Alexander
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14. Informant J. W. Jones
(Address) Pocatello, Idaho.

15. Filed 2-1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 16th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 5/14, 1926, to 5/16, 1929
that I last saw him alive on 5/16, 1929
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) Earl D Jones M. D.
5/16, 1929 (Address) Roberts Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Annis, Idaho. Date of Burial: 5/18/29 19

20. Undertaker: A B Eckersell Address: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 66984

PLACE OF DEATH

County of Jefferson
City of Rigby

CERTIFICATE OF DEATH

Registration District No. 98
Primary Registration District No. 2176
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 40

2. FULL NAME Melinda Gardiner.

(a) Residence. No. ..... St. 44
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F. M.
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
~~[illegible]~~ (or) WIFE of Jesse Gardner

6 DATE OF BIRTH (month, day and year) Feb. 16 1870

7 AGE: Years 59 | Months 4 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10 NAME OF FATHER: Fredrick Voyce
11 BIRTHPLACE OF FATHER (city or town) (State or country): England
12 MAIDEN NAME OF MOTHER: Laura Fyfield.
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Iowa

14 Informant: Jesse Gardiner
(Address) Rigby Idaho R. #3

15 Filed 8-1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month), 25 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1929, to June 25, 1929, that I last saw her alive on June 25, 1929, and that death occurred, on the date stated above, at 8:30 p m.

The CAUSE OF DEATH* was as follows:
Ca of Womb - Secondary anemia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) N. A. West, M. D.
6/26, 1929 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rigby, Idaho.
Date of Burial: 6/28/29 19

20. Undertaker: A B Eckersell
Address: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 31 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66985

Registration District No. 45

Primary Registration District No.

Local Registrar's No. 4

PLACE OF DEATH

County of Kootenai

City of Spirit Lake

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Loyd E. Marquette

(a) Residence. No. Spirit Lake St. 1000 New Port Wn

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Dec 31, 1928

7. AGE — Years: | Months: 3 | Days: 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Port Washington

PARENTS

10. NAME OF FATHER Loyd Marquette

11. BIRTHPLACE OF FATHER (city or town) (State or Country) —

12. MAIDEN NAME OF MOTHER Beatrice Hill

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Loyd Marquette

(Address) New Port Wn

15. Filed Apr 1, 1929. A. C. Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-31-29, 19—, to 3-31-, 1929 that I last saw h~~im~~ alive on 3-31-, 1929 and that death occurred, on the date stated above, at 11-55P m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) measles

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? Newport, Wn

Did an operation precede death? no Date of 3/31-29

Was there an autopsy? no

What test confirmed diagnosis? Lungs/Pathlo

(Signed) Nelson L. Jersey, M. D.

3-31-29, 1929 (Address) Spirit Lake Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spirit Lake — Date of Burial: 4/3 1929

20. Undertaker: R B Mooney — Address: Coeur d'Alene, Ida.

RECEIVED JUL 31 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66986

Registration District No. 45
Primary Registration District No.
Local Registrar's No. 3

PLACE OF DEATH
County of Kootenai
City of Spirit Lake.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Peter Backstrom

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Marica Backstrom

6. DATE OF BIRTH (month, day and year) Sept 29 - 1855

7. AGE Years	Months	Days	If LESS than 1 day,
73	5	14	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER Carson Backstrom
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden.
12. MAIDEN NAME OF MOTHER Anna Marica
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden.

14. Informant Augusta M. Larson.
(Address) Spirit Lake Ida

15. Filed Mch 14, 1929 A C Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 8, 1929, to , 19
that I last saw h[illegible] alive on Mch 8, 1929
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Two previous attacks
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) A C Spooner, M. D.
Mch 14, 1929 (Address) Spirit Lake Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Green Wood Cemetery Spirit Lake.	March 16 - 1929
20. Undertaker Cassidy Funeral Home	Address Rathdrum Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 31 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66987

Registration District No. 45
Primary Registration District No.
Local Registrar's No. 2

PLACE OF DEATH

County of Kootenai
City of Spirit Lake

(No. Spirit Lake Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Betty Jean Infant

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	white	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, 3 hrs. hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Spirit Lake Idaho

PARENTS

10. NAME OF FATHER Elmer Oscar Everson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) McMillan, Michigan
12. MAIDEN NAME OF MOTHER Dorothy Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Grand Mere Mich

14. Informant Elmer Everson
(Address) Edgemere Idaho

15. Filed 2-15-, 1929 A C Spooner
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14, 1929, to Feb 14, 1929
that I last saw her alive on Feb 14, 1929
and that death occurred, on the date stated above, at 7 15 P m.
The CAUSE OF DEATH* was as follows:

Premature Infant

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Appearance

(Signed) Nelson Hersey, M. D.
Feb 15, 1929 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood Cemetery Spirit Lake	2/16 1929
20. Undertaker	Address
Cassedy Funeral Home	Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 31 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66988

PLACE OF DEATH
County of Kootenai
City of Spirit Lake

Registration District No. 45
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

2. FULL NAME Ernest Wood 11a

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lucile Wood.

6. DATE OF BIRTH (month, day and year) March 16 1904

7. AGE Years 24 Months 10 Days 18 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mill Foreman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer L. L. Barge Box Factory

9. BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS
10. NAME OF FATHER M. C. Wood
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina
12. MAIDEN NAME OF MOTHER Ettie Caudill
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14. Informant M. C. Wood
(Address) Globe Hotel - Spokane

15. Filed 2-5, 1929 A C Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1929, to Feb 2, 1929
that I last saw him alive on Feb 1, 1929
and that death occurred, on the date stated above, at 4:15 A m.
The CAUSE OF DEATH* was as follows:
Flu - Pneumonia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Cardiac Failure
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Hotel
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) Nelson L. Hersey, M. D.
Feb 5, 1929 (Address) Spirit Lake Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cemetery Coeur d'Alene Ida. Date of Burial 2/6 1929

20. Undertaker Cassedy Funeral Home Address Rathdrum Ida.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66989

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 109
(No. Home Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

197

2. FULL NAME William E. Polgate

(a) Residence: No. 210 Garden St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Rose Polgate

6. DATE OF BIRTH (month, day and year) July 24, 1887

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	41	11	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington

PARENTS

10. NAME OF FATHER Geo Polgate
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Jane Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Rose Polgate
(Address) Coeur d'Alene Ida.

15. Filed 7/29, 1929. H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at 4:30 P m.
The CAUSE OF DEATH* was as follows:
Gun Shot Wound in Back (Homicidal)
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? no Date of ____
Was there an autopsy? no
What test confirmed diagnosis? ____
(Signed) F B Mooney Coroner, M.D.
July 19, 1929 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	July 22 1929

20. Undertaker F B Mooney Address Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 85990

PLACE OF DEATH
County of Kootenai
City of Bayview

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 11d
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Johnson

(a) Residence. No. St. Bayview, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of August W. Johnson

6. DATE OF BIRTH (month, day and year) November 13 1865

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	8	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Chas. Swanson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant August W. Johnson
(Address) Bayview, Idaho.

15. Filed 7/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 14 (Day) 1929 (Year)

I HEREBY CERTIFY, That I attended deceased from March 13, 1928, to July 14, 1929
that I last saw her alive on June 2, 1929
and that death occurred, on the date stated above, at 5:18 P m.

The CAUSE OF DEATH* was as follows:
Adeno Carcinoma = primary of Fallopian tube: involving all abd viscera
(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Bayview Idaho
Did an operation precede death? Yes Date of Mar. 19. 1928
Was there an autopsy? No
What test confirmed diagnosis? clinical + Micro

(Signed) Maurice Shepard M. D.
7/15, 1929 (Address) Spokane Wn

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood	July 16 19 29
20. Undertaker: Hennessey & Calloway	Address: 30W 3rd.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66991

PLACE OF DEATH
County of Kootenai
City of Coeur d Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 11

(No. 1898) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kendell Lantz

(a) Residence. No. ... St. Toledo, Ore.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 27			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberman Logger
(b) General nature of industry, business, or establishment in which employed (or employer) Winton Lumber Co
(c) Name of employer Coeur d'Alene Ida.

9. BIRTHPLACE (city or town) ...
(State or country)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) ...
(State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) ...
(State or Country)

14. Informant Winton Lumber Co
(Address) Coeur d'Alene Ida

15. Filed 7/29, 1929 H. J. Thuesen
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 2 P M m.

The CAUSE OF DEATH* was as follows:
a Accidentally Killed Camp 14 Winton Lumber Co. (Head Crushed)
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? ... Date of ...
Was there an autopsy? ...
What test confirmed diagnosis? ...

(Signed) R B Mooney Coroner M. D.
7/8, 1929 (Address) ...

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation,~~ or Removal	Date of Burial
Goshen, Ind.	7/8 1929

20. Undertaker R B Mooney Address Coeur d'Alene Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66992

PLACE OF DEATH
County of Kootenai
City of Rathdrum
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 112
(No. 129)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Simon Beck

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W.	Widower

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Ellen

6. DATE OF BIRTH (month, day and year) Aug 2, 1850

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	10	12	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired - Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Jamestown (State or country) Penn.

PARENTS
10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Mrs O. H. Fuller
(Address) 3033 - 60 Ave S.W. Seattle Wash

15. Filed 7/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1924, to June 15, 1929
that I last saw h— alive on June 14, 1929
and that death occurred, on the date stated above, at 2.00 P. m.
The CAUSE OF DEATH* was as follows:
Chronic interstitial
Nephritis
about 5
(duration) yrs. mos. ds.
CONTRIBUTORY Old age
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Frank Wm, M. D.
6/17, 1929. (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
McCassedy Funeral Home	6/ 19
20. Undertaker	Address
Riverview Cemetery Rathdrum	Rathdrum

RECEIVED AUG 9 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

DO NOT WRITE IN THIS SPACE

State File No. 66994

Local Registrar's No. 115

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ambro Bettes

(a) Residence. No. 814 Hastings St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of Evelyn Bettes

6. DATE OF BIRTH (month, day and year) March 22, 1851

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	3	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Promotor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER John Bettes

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Sarah Ferguson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs Evelyn Bettes

(Address) Coeur D'Alene Ida

15. Filed 7/29, 1929 W. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to , 19

that I last saw him alive on July 2, 1929

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. O'Brien, M. D.

7/25/29, 19 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	July 5 1929

20. Undertaker R. D. Mooney Address C d'A Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66995

PLACE OF DEATH

County of Kootenai

City of Rathdrum

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 115

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martha Ann Trueblood. 24 B

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of (or) WIFE of~~ L. P. Trueblood.

6. DATE OF BIRTH (month, day and year) Nov. 30 – 1854

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
75	7	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clearmont Mo.

PARENTS

10. NAME OF FATHER James. Gray.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER — Houston

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N Carolina

14. Informant C. G. Trueblood
(Address) Spokane, Wash

15. Filed 7/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:
Deceased died suddenly at her home investigated cause of death and am satisfied at was Chronic Myocarditis (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Old Age

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Frank Wenz M. D.

July 13, 1929 (Address) Rathdrum Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pine Grove Cemetery - Rathdrum

Date of Burial: 7/14 1929

20. Undertaker: Cassedy Funeral Home

Address: Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66996

PLACE OF DEATH
County of Kootenai
City of Rathdrum
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 116

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Poirier

(a) Residence. No. 46 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Phoebe Poirier

6. DATE OF BIRTH (month, day and year) June 8—1852

7. AGE	Years	Months	Days	If LESS than 1 day,
	77	1	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) St. John Baptist (State or country) Canada

PARENTS

10. NAME OF FATHER Edward Poirier
11. BIRTHPLACE OF FATHER (city or town) St. John Baptist (State or Country) Canada
12. MAIDEN NAME OF MOTHER Dorothea Wilcott
13. BIRTHPLACE OF MOTHER (city or town) St. John (State or Country) Dimoske

14. Informant Mrs Phoebe Poirier
(Address) Rathdrum Ida.

15. Filed 7/29, 1929 W. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 23. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15. 1929, to July 23. 1929
that I last saw h— alive on July 23. 1929
and that death occurred, on the date stated above, at 12:25 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) 3 or 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypostatic Congestion
right lung (duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Frank Ware, M. D.
7/24. 1929. (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Grove Cemetery Rathdrum	7/25 1929
20. Undertaker	Address
Laverdy Funeral Home	Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66997

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1050
(No. Kootenai County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 117

2. FULL NAME Daniel Frazier - Rathdrum, Idaho 74a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) — — —

7. AGE Years 67 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) San Francisco
(State or country) California

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) "
(State or Country)
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14. Informant Mrs. John Brown
(Address) Rathdrum Idaho

15. Filed 7/29, 1929. H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1923, to July 12, 1929
that I last saw him alive on July 11, 1929
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.
(Stroke Apoplexy
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) General Atheroma
..... (duration) 6 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Frank Wenz, M. D.
7/13, 1929 (Address) Rathdrum N.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pine Grove Cemetery Rathdrum
Date of Burial: 7/17 1929

20. Undertaker: Cassedy Funeral Home
Address: Rathdrum

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66998

PLACE OF DEATH
County of Kootenai
City of Athol

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 118

161a

2. FULL NAME Frank Oliver Bohn - Belmont - Idaho

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) June 17, 1929

7. AGE Years | Months | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Athol Idaho

PARENTS
10. NAME OF FATHER C. O. Bohn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minnesota
12. MAIDEN NAME OF MOTHER Viola Duvall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Carolina

14. Informant C. O. Bohn
(Address) Athol, Idaho

15. Filed 7/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to July 13, 1929
that I last saw him alive on July 7, 1929
and that death occurred, on the date stated above, at 3:00 A. m.
The CAUSE OF DEATH* was as follows:
Premature birth - 6½ months gestation - inability to assimilate food
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) Frank Wenz, M. D.
7/15, 1929 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pine Grove Cemetery - Rathdrum
Date of Burial: 7/15 1929

20. Undertaker: Cassedy Funeral Home
Address: Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66999

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 119

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Orlando Webster Brooks 90

(a) Residence. No. 1317 Coeur d'Alene Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida M Brooks

6. DATE OF BIRTH (month, day and year): May 25 1856

7. AGE: Years 73, Months 2, Days 5. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lawrence Kansas

PARENTS
10. NAME OF FATHER: Geo Brooks
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill
12. MAIDEN NAME OF MOTHER: P. Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill

14. Informant: Ida M Brooks
(Address) Coeur d'Alene Ida

15. Filed 8/1, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1929, to July 30, 1929
that I last saw him alive on July 26, 1929
and that death occurred, on the date stated above, at 4:15 P m.
The CAUSE OF DEATH* was as follows:
Cardio-Renal disease
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) E. H. Teed, M. D.
8-1-, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery
Date of Burial: Aug 1 1929 July 31

20. Undertaker: F B Mooney
Address: Cal A Ida

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67000

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 120

(No.) 749
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oscar J. Larson

(a) Residence. No. 724 Mill St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Belle Larson

6. DATE OF BIRTH (month, day and year) 1885-2-22

7. AGE	Years	Months	Days	If LESS than 1 day,
	44	5	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumber grader
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Lars Larson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Martha Rhodestrom
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Belle Larson
(Address) Coeur d'Alene, Ida

15. Filed 8/5, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9, 1929, to Aug 2, 1929
that I last saw h~~e~~ alive on Aug 2, 1929
and that death occurred, on the date stated above, at 8 40 P m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemmorhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) E. H. Teed, M. D.
8-3-, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CdAlene	8-4 1929
20. Undertaker	Address
Cassedy Funeral Home	CdAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

DO NOT WRITE IN THIS SPACE

State File No. 67001

Local Registrar's No. 101

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gilbert Ambrose Pyle

(a) Residence. No. 402 - Dollar St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE W.

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Leah Smith Pyle

6. DATE OF BIRTH (month, day and year) 1895 - 9 - 1

7. AGE Years 33 Months 10 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Warehouse man

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mont

PARENTS

10. NAME OF FATHER Fred M. Pyle

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Anna Anderson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Leah L. Pyle

(Address) 402 Dollar St.

15. Filed July 10, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 4th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov., 1928, to July, 1929

that I last saw him alive on July 3rd, 1929

and that death occurred, on the date stated above, at 5:56 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? In military Service

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Harold J. Sturges, M. D.

July 6th, 1929 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene

Date of Burial 7-6 1929

20. Undertaker Cassedy Funeral Home

Address C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67002

PLACE OF DEATH
County of Kootenai
City of Gibbs

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 102

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

128

2. FULL NAME Mead Van Slate

(a) Residence. No. Gibbs St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 19, 1862

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	11	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sobrer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Appleton Wise

PARENTS

10. NAME OF FATHER: Peter Van Slate
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wise
12. MAIDEN NAME OF MOTHER: Emily St Mitchell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wise

14. Informant: Mrs Mead Van Slate
(Address) Gibbs, Ida.

15. Filed July 29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1929, to July, 1929
that I last saw him alive on July 22, 1929
and that death occurred, on the date stated above, at 2:15 P. m.
The CAUSE OF DEATH* was as follows:
Nephritis

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy
(Signed) Harold J. Sturges, M. D.
7-24, 1929 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Thomas Cemetery
Date of Burial: July 27 1929

20. Undertaker: R. B. Mooney
Address: Coeur d'Alene Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67003

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1030
Local Registrar's No. 108

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lawrence Roy Wilson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1888-12-22

7. AGE	Years	Months	Days	If LESS than 1 day,
	40	7	3	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Samuel Wilson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.
12. MAIDEN NAME OF MOTHER Ella Rogers.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind.

14. Informant Emery E. Wilson
(Address) White Sulphur Springs, Mont.

15. Filed July 29, 1929 H. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22, 1929 to July 25, 1929
that I last saw h[illegible] alive on July 25, 1929
and that death occurred, on the date stated above, at 1:45 P. m.
The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Spinal Punct. Bacteriological Exam.

(Signed) J. C. Burgess M. D.
July 27, 1929 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CdAlene	7-27 1929
20. Undertaker	Address
Cassedy Funeral Hm	CdAlene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67004

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 104

(No. Home Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Henry Hendrix

(a) Residence. No. Rose Lake, Ida. St. Rose Lake Ida
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) unknown

7. AGE Years 73 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisc.

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Home Hospital
(Address) Coeur d'Alene

15. Filed 7/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28, 1929, to July 19, 1929

that I last saw him alive on July 19, 1929

and that death occurred, on the date stated above, at 6 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Rose Lake, Idaho

Did an operation precede death? yes Date of 7-16-29

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Harold J. Sturges, M. D.

7-22, 1929 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rose Lake Ida — Date of Burial 7/24 1929

20. Undertaker R B Mooney — Address Pal'd Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67007

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 107

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1010

2. FULL NAME Julia E. Boughton

(a) Residence No. 715 - A St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.

4. COLOR OR RACE W.

5. Single, Married, Widowed, or Divorced (write the word) widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm H. Boughton

6. DATE OF BIRTH (month, day and year) 1847-12-6

7. AGE Years 81 Months 7 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10. NAME OF FATHER John Ball.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....

12. MAIDEN NAME OF MOTHER Lucy E. West

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant E. D. Boughton
(Address)

15. Filed 7/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to July 17, 1929 that I last saw her alive on July 17, 1929 and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis -

..... (duration) Not yrs. known ~~mos.~~ ds.

18. Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? J. C. Dwyer

(Signed) ....., M. D.

July 18, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene — Date of Burial 7-19 1929

20. Undertaker Cassedy Funeral Home — Address C D Alene,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67008

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 108

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

16d

2. FULL NAME Duncan H Ferguson
(a) Residence. No. 733 Seventh St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 19, 1844

7. AGE Years 85 Months 11 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS
10. NAME OF FATHER D H Ferguson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Frank S. Ferguson
(Address) Portland, Ore.

15. Filed 7/29, 1929. H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 30, 1929, to July 15, 1929
that I last saw him alive on July 15, 1929
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows:
Senility
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Chr. Myocarditis.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Harold J. Sturges, M. D.
7-19, 1929 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cemetery
Date of Burial July 20 1929

20. Undertaker R B Moore
Address Cda 9 [illegible]

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 22 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Bovill

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 66

Primary Registration District No. 214-5

(No. ..... St.)

File No. 67009

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Garrison Herbert Ingraham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Widower

6. DATE OF BIRTH Feby 13 1844
(Month) (Day) (Year)

7. AGE 85 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Mason
(b) General nature of industry, business or establishment in which employed (or employer) N.Y. State

9. BIRTHPLACE (State or Country) Otto - N.Y.

10. NAME OF FATHER Peter Ingraham

11. BIRTHPLACE OF FATHER (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER Unknown Lucy before

13. BIRTHPLACE OF MOTHER (State or Country) N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gal. Shook
(Address) Bovill, Idaho

15. Filed June 1, 1929 E. B. Flasher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1929, to May 31 1929
that I last saw h..... alive on May 31 1929
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. 3 mos. ..... ds.

Contributory (Secondary) none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. H. Brown M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pilot Rock Ore DATE OF BURIAL June 4 1929

20. UNDERTAKER Jno Pickard ADDRESS Troy Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. RECEIVED JUL 22 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 67010

Registered No.

Registration District No. 66

Primary Registration District No. 2148

1. PLACE OF DEATH

County of Latah

City of Bovill (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lelia May Fisher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct 13 - 1885 (Month) (Day) (Year)

7. AGE: 43 Yrs. 6 Mos. 21 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Chas Sanderson

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Charlett White

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Irwin L. Fisher

(Address) Bovill Idaho.

15. Filed May 6 1929

E. B. Flasher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 3 - 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27 - 1929 to May 3 - 1929 that I last saw her alive on April 30 - 1929 and that death occurred on the date stated above, at 9:50 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Enteritis.

(Duration) Yrs. mos. ds.

Contributory (Secondary) Tuberculosis of Lung

(Duration) 10 yrs. mos. ds.

(Signed) F. C. Gibson M. D.

19 (Address) Potlatch Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow Ida DATE OF BURIAL: May 6 1929

20. UNDERTAKER: E. H. Irwin ADDRESS: Potlatch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67011

PLACE OF DEATH
County of Latah
City of Bovill

Registration District No. 66
Primary Registration District No. 2145
(No. .....)
(If death occurred in a hospital or institution give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Charles Albritth

(a) Residence. No. Bovill - Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 28 1901

7. AGE Years 27 Months 3 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Potlatch Lum. Co.

9. BIRTHPLACE (city or town) (State or country) Wash.

PARENTS

10. NAME OF FATHER A Albright
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wis
12. MAIDEN NAME OF MOTHER Winney Blighton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant W. H. Albright
(Address) Calfox Wash.

15. Filed Mch. 11, 1929 E. B. Flasher Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) ~~28~~ 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw him alive on Mar 9, 1927
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Rupture of heart valve
Instant death.
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Athletic Heart.
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) P H Brown, M. D.
....., 19.... (Address) Bovill Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Palouse Wash. Date of Burial March 13 1929

20. Undertaker E. M. Drum Palouse Wash. Address

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH RECEIVED JUL 22 1929

Registration District No. 66

County of Latah

Primary Registration District No. 2148

File No. 67012

City of Bovill-Ida (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John O'Neill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 19 (Day) 1855 ~~1929~~ (Year)

7. AGE: 73 Yrs. 9 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Logger

(b) General nature of industry, business or establishment in which employed (or employer): Lumber Industry

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. B. Flasher

(Address) Bovill - Ida

15. Filed Mch. 6 1929 E. B. Flasher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 164 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1929, to Mar 6 1929 that I last saw him alive on Mar 6 1929, and that death occurred on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) P H Brown M. D.

Mar 6 1929 (Address) Bovill Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 25 yrs. ..... mos. ..... days. In the State 26 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? here

Former or usual residence Wisconsin

19. PLACE OF BURIAL OR REMOVAL: ~~Palouse Wash~~ Oconto Wis. DATE OF BURIAL: Mar 7 1929

20. UNDERTAKER: P M Irwin ADDRESS: Palouse Wash

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67013

PLACE OF DEATH

County of Latah
City of Troy

Registration District No. 64
Primary Registration District No. 2144
Local Registrar's No. 164

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Andrew Magnus Anderson

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Sarah Anderson

6. DATE OF BIRTH (month, day and year) Feb 5 1847

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	5	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Andrew Olson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Anna Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs Ruth Kelberg
(Address) Troy Idaho

15. Filed July 31, 1929 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to July 31, 1929
that I last saw him alive on July 30, 1929
and that death occurred, on the date stated above, at 5:30 m.
The CAUSE OF DEATH* was as follows:

Senility.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. A. Meyer, M. D.
July 31, 1929 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Westdale cem	Aug. 2 1929
20. Undertaker	Address
John J. Pickerd	Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67014

PLACE OF DEATH
County of Latah
City of Troy
Registration District No. 64
Primary Registration District No. 2144
Local Registrar's No. 69

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna Glasen

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Vaclav Glasen

6. DATE OF BIRTH (month, day and year) Feb 2 1864

7. AGE Years	Months	Days	If LESS than 1 day,
65	4	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Czechoslovakia

PARENTS

10. NAME OF FATHER Vaclav Mares
11. BIRTHPLACE OF FATHER (city or town) (State or Country) czechoslavakia
12. MAIDEN NAME OF MOTHER Vackova
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Czechoslavakia

14. Informant Vaclav Glasen
(Address) Troy Ida

15. Filed July 23, 1929 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1928, to July 22, 1929
that I last saw h[illegible] alive on July 22, 1929
and that death occurred, on the date stated above, at 3:25 P. m.
The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Chas. L. Gutman M. D.
July 23, 1929 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buchanan cem	July 24 1929
20. Undertaker	Address
John J. Puckett	Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67015

PLACE OF DEATH
County of Latah
City of Troy
Registration District No. 64
Primary Registration District No. 2144
Local Registrar's No.
(No.) 881
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hans Eriksen

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	8	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): U S
12. MAIDEN NAME OF MOTHER: U
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): U

14. Informant: Mrs Hans Eriksen
(Address): Troy Ida.

15. Filed July 31, 1929 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11, 1929, to July 12, 1929
that I last saw him alive on July 12, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Chas A. Meyer, M. D.
July 14, 1929 (Address) Troy Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Westlake cem	July 15 1929
20. Undertaker	**Address**
John J Pickard	Troy Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67016

PLACE OF DEATH

County of Lemhi

City of Lemhi

Registration District No. 42

Primary Registration District No. 2153

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nelson Friend

(a) Residence. No. Salmon Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

11 b

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Friend Deceased.

6. DATE OF BIRTH (month, day and year) May 23rd 1860

7. AGE 69 Years | Months | 8 Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Union Co Ohio

PARENTS

10. NAME OF FATHER Isaac Friend

11. BIRTHPLACE OF FATHER (city or town) (State or Country) —

12. MAIDEN NAME OF MOTHER Eliza Pitts

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Clyde Friend
(Address) Wynona Okla

15. Filed 6-24, 1929 John L Bubblis
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 31st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-19-, 1929, to 5-31-, 1929
that I last saw him alive on 5-31-, 1929
and that death occurred, on the date stated above, at 1 p.m. m.
The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis c̄ Acute Myocarditis (duration) yrs. mos. 25-30 day

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical diagnosis

(Signed) John L. Bubblis, M. D.

6-24, 1929 (Address) Lenore

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salmon Cemetery | Date of Burial 6-3- 1929

20. Undertaker William C. Doebler | Address Salmon, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 19 1929

PLACE OF DEATH

County of Lemhi

City of Salmon

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67017

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Ella Manfull.

(a) Residence. No. Salmon Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 22.

7. AGE Years 72. Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House keeping.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winona Minnesota

PARENTS

10. NAME OF FATHER Henry Billings-

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER Amanda Warr.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Mrs Maud Sternberg

(Address)

15. Filed 7/10, 1929 Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 23rd 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to June 23, 1929 that I last saw her alive on June 23, 1929 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms of Cancer

(Signed) F. J. Wright, M. D.

, 19 (Address) Salmon

*State [illegible] DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE [illegible]ate (1) MEANS AND NATURE OF INJURY, and (2) whether [illegible]CIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salmon Cemetery

Date of Burial 6/25th 1929

20. Undertaker Wm C. Doebler

Address Salmon Ida

RECEIVED JUL 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67018

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. H
Primary Registration District No. 2116
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Patrick H Kane

(a) Residence. No. Snowy Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Divorced

5a. If married, widowed, or divorced
~~Husband of~~ (or) ~~Wife of~~ Mrs Irwin Goldsmith

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mass

PARENTS

10. NAME OF FATHER James Kane
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Doris Kane Gawen
(Address) Caldwell Idaho

15. Filed 7/19, 1929 C. F. Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18, 1929, to June 19, 1929, that I last saw him alive on June 19, 1929, and that death occurred, on the date stated above, at 5-4- m.

The CAUSE OF DEATH* was as follows:

Anemia do not know Cause
No history Patient when seen Emaciated, probably died
before + At least (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia terminal of Os Calles Mineral Empyema (duration) Don't Know yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Tuberculin, Roentgen, Clinical

(Signed) D. E. Wright, M. D.
6/23, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	6/23rd 1929
20. Undertaker	Address
Am C Doeble	Salmon Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67019

PLACE OF DEATH

County of Lemhi

City of Tendoy Ida.

Registration District No. 41

Primary Registration District No. 2116

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 881

2. FULL NAME Mrs Martha J. Gage

(a) Residence. No. Tendoy Ida Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Gage

6. DATE OF BIRTH (month, day and year) Jan. 18. 71

7. AGE 88 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER Jacob Nuckette.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Martha Brown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Mrs Gertie Trowbridge
(Address) Tendoy Ida Ida

15. Filed June 17. 1929 Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 17th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1929, that I last saw her alive on June 15 1929 and that death occurred, on the date stated above, at 12-15 P m.

The CAUSE OF DEATH* was as follows: Myocarditis following attack of Influenza.
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical signs

(Signed) C. E. Hatton, M. D.
June 17 1929. (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Webster City Iowa — Date of Burial: 19

20. Undertaker: Jas C Dochld — Address: Salmon, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 19 1929

PLACE OF DEATH

County of Lemhi

City of

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 41

Primary Registration District No. 2116

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67020

Local Registrar's No.

74a

2. FULL NAME Mrs. Katherine Burns

(a) Residence. No. Salmon St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 66 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): New York State

PARENTS

10. NAME OF FATHER: Thomas Honlon

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Margaret Leonard

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Massachusetts

14. Informant: Mrs. Asa Simers "Sister"
(Address) Salmon, Idaho.

15. Filed June 21, 1929 Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1917 to , 1929

that I last saw her alive on May 28, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Paralysised 12 years. Death occurred suddenly from cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) [illegible], M. D.

June 7, 1929 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon | Date of Burial: June 7 1929

20. Undertaker: Wm C. Foebler | Address: Salmon, Ida.

RECEIVED JUL 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67021

PLACE OF DEATH
County of Lemhi
City of Hot Springs

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME E. W. Herbert

90

(a) Residence. No. Hot Springs Solmon Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: about 75 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Quartz Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS
10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: Wm C Doebler
(Address) Solmon Idaho

15. Filed 7/10, 1929 Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1929, to May 15, 1929
that I last saw him alive on May 15, 1929
and that death occurred, on the date stated above, at 3 30 P m.
The CAUSE OF DEATH* was as follows:
Mitral regurgitation

About 3 years (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
May 23, 1929 (Address) Solmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Solmon Cemetery | Date of Burial: 5 20th 1929

20. Undertaker: Wm C Doebler | Address: Solmon Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 19 1929

PLACE OF DEATH

County of Lemhi

City of Salmon

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 41

Primary Registration District No. 2116

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 67022

Local Registrar's No. .....

2. FULL NAME Donald Ray Black.

(a) Residence. No. Salmon Idaho. St. 9
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 13. 1928.

7. AGE: 6 Years | Months: 8 | Days: ~~4~~ 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salmon Idaho.

PARENTS

10. NAME OF FATHER W. T. Black

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nephi, Utah.

12. MAIDEN NAME OF MOTHER Florence Nickell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Irwin, Idaho.

14. Informant W. T. Black.
(Address) Salmon Ida.

15. Filed 7/10, 1929 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 17th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 17, 1929

that I last saw him alive on May 17, 1929

and that death occurred, on the date stated above, at 5-A- m.

The CAUSE OF DEATH* was as follows:

Whooping cough

Acute 4 weeks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? —— Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chas F Hammer, M. D.

May 25, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery | Date of Burial: 5-18" 1929

20. Undertaker: Wm C Doebler | Address: Salmon Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 19 1929

PLACE OF DEATH

County of Lemhi

City of Salmon

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 21

Primary Registration District No. 2116

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 67023

Local Registrar's No. .....

160

2. FULL NAME Molley Donlan

(a) Residence. No. North Fork Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 23. April 1929

7. AGE Years Months Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salmon Idaho

PARENTS

10. NAME OF FATHER James H. Donlan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Red Lodge Mont.

12. MAIDEN NAME OF MOTHER Frances Dean

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bibbronsville Idaho

14. Informant J. H. Donlan
(Address) Salmon Ida.

15. Filed 7/10, 1929 Otto Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 11th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 23, 1929, to May 11, 1929
that I last saw her alive on May 11, 1929
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Icterus Icterus

..... (duration) ..... yrs. ..... mos. 18 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Hammer, M. D.

June 15, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salmon Cemetery — Date of Burial 5/11" 1929

20. Undertaker Wm C Doehler — Address Salmon Ida.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUL 17 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 47

Primary Registration District No.

File No. 67024

Registered No. 143

1. PLACE OF DEATH

County of Lewis

City of Nezperce Idaho (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Harrison Mitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	white	Married

6. DATE OF BIRTH.

October 14 1868
(Month) (Day) (Year)

7. AGE

60 Yrs. 8 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Des Moines Iowa

10. NAME OF FATHER Milton Mitchel

11. BIRTHPLACE OF FATHER

(State or Country) Fulton Co Indiana

12. MAIDEN NAME OF MOTHER Phebe Reeves

13. BIRTHPLACE OF MOTHER

(State or Country) Peoria Walnut Co Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Myrtle Mitchell

(Address) Nezperce, Idaho

15.

Filed July 15 1929

Albert Huff
Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1012

July 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-30 1929, to 6-6 1929, that I last saw him alive on 6-6 1929, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) Cancer

(Duration ..... yrs. 4 mos. ..... ds.

(Signed) C Taylor M. D.

7-6 1929 (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF [illegible] OR REMOVAL Clarkston Wash.

DATE OF BURIAL July 8 1929

20. UNDERTAKER Albert Huff

ADDRESS Nezperce Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67025

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 30
Primary Registration District No. 2129
Local Registrar's No. 13

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel A. Dinsmore

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 4/18/1859

7. AGE Years 79 Months 3 Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry, business, or establishment in which employed, (or employer)
(c) Name of employer Craig Mountain Lumber Co.

9. BIRTHPLACE (city or town) (State or country) Pa.

PARENTS
10. NAME OF FATHER Adam Dinsmore
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Susan Keeley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant Jack Dinsmore
(Address) Winchester Idaho

15. Filed 7/30, 1929 R. E. Durrell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July - 7, 1929, to July - 24, 1929
that I last saw him alive on July - 24, 1929
and that death occurred, on the date stated above, at 3:30 a.m.
The CAUSE OF DEATH* was as follows:
General Peritonitis following Carcinoma of Stomach ??
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Carcinoma ?
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) John F. Gist, M.D.
July/24, 1929 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 7/25 1929

20. Undertaker Brower-Warm Co
Address Lewiston, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67026

PLACE OF DEATH
County of Lincoln
City of Shoshone

Registration District No. 16
Primary Registration District No. 1016
Local Registrar's No. 910

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

65a

2. FULL NAME Lenora Ann Borden

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: C F Borden

6. DATE OF BIRTH (month, day and year): July 12 - 1866

7. AGE: Years 62, Months 11, Days 3. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Novia Scotia

PARENTS
10. NAME OF FATHER: Robt W Parker
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Novia Scotia
12. MAIDEN NAME OF MOTHER: Mary Ann Hutchison
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Novia Scotia

14. Informant: C F Borden
(Address): Shoshone

15. Filed June 17, 1929 J L Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1929 (Year) 5:20

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1929, to June 15, 1929, that I last saw her alive on June 18, 1929, and that death occurred, on the date stated above, at 5:40 p.m.

The CAUSE OF DEATH* was as follows: Pecakemia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Flu.

..... (duration) ..... yrs. 4 mos. ..... ds.

18. Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? G. Blood

(Signed) R. Bell M. D.
June 17, 1929 (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Shoshone Ida. Date of Burial: 6-17 1929

20. Undertaker: C E Hickok Address: Shoshone

FORM V. S. No. 5-25 M. 1-19.

AUG 9 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison

City of Hibbard.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

File No. 67028

Registered No. 62

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert James Sellers.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: December (Month) 3. (Day) 1928 (Year)

7. AGE: X Yrs. 8 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Hibbard. Ida.

10. NAME OF FATHER: Joseph F. Sellers.

11. BIRTHPLACE OF FATHER (State or Country): Mexico.

12. MAIDEN NAME OF MOTHER: Merlile Lucas.

13. BIRTHPLACE OF MOTHER (State or Country): Plano. Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph F. Sellers.

(Address) Rexburg. # 3.

15. Filed 8/5 1929 J. Wyoming Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1929, to Aug 4 1929, that I last saw him alive on Aug 4 1929, and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows: Abscess Brain

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Cerebro Spinal Meningitis.

(Duration) ..... yrs. ..... mos. 30 ds.

(Signed) H. B. Rigby M. D.

Aug 5 1929 (Address) Rexburg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plano. Ida.

DATE OF BURIAL: Aug. 6th 1929.

20. UNDERTAKER: Verd. J. Keller.

ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH RECEIVED AUG 9 1929

County of Madison

City of Salum

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

File No. 67029

Registered No. 61

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl Keith Hendricks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH ..... (Month) ..... (Day) ..... 1 (Year)

7. AGE: 16 Yrs. ..... Mos. 9 ds. 14

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): Student of School Working with Father

9. BIRTHPLACE (State or Country): La Grand Oregon.

10. NAME OF FATHER: John H. Hendricks

11. BIRTHPLACE OF FATHER (State or Country): Richmond Utah.

12. MAIDEN NAME OF MOTHER: Clara Wahlem.

13. BIRTHPLACE OF MOTHER (State or Country): Burns Switzerland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Harllow Hendricks

(Address) Rexburg Rout # 2

15. Filed 7/31 1929 J. Rysonwg Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July ~~13~~ 30th--1929 (Month) (Day) 19 (Year) 18

17. I HEREBY CERTIFY, That I attended deceased from ..... 19 ....., to ..... 19 ....., that I last saw h..... alive on ..... 19 ....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Drowning

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. Schwendiman M. D.

7/31 1927 (Address) Rexburg, Idaho Coroner Madison Co.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho

DATE OF BURIAL ..... 19 .....

20. UNDERTAKER: [signature]

ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67030

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2170
(No.)

Local Registrar's No. 60

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Cecil George Englund

(a) Residence. No. 110 St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 24 1914

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
15	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Herbert Idaho

PARENTS

10 NAME OF FATHER Constantine Englund

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Katherine Ronnenkamp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hibbard Idaho

14 Informant Constantine Englund
(Address) Rexburg Idaho

15 Filed 7/31, 1929 J. Rigby Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 29 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1929, to July 29, 1929.
that I last saw him alive on July 29, 1929.
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis following infection of accidental scalp wound

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Scalp laceration accidental

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. W. Englund, M. D.

7/31, 1929 (Address) Rexburg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Rexburg	July 31 1929

20. Undertaker C. O. Eckersell Address Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67031

PLACE OF DEATH
County of Madison
City of Rexburg.

Registration District No. 100
Primary Registration District No. 278
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

2. FULL NAME Joe William Nielson

(a) Residence. No. Rexburg St. 90
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 30th 1861

7. AGE — Years: 68 — Months: 2 — Days: 3 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Denmark

PARENTS

10. NAME OF FATHER: Niels Nielsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Anna Marie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Vada Niederer
(Address): Rexburg Idaho

15. Filed 7/26, 1929 — Wyoming Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 26th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Dropped dead from heart failure as near as could be determined

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

7/26, 1929 (Signed) F. Schwendiman, M. D.
(Address) Coroner Rexburg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sugar City	7-28 1929
20. Undertaker	Address
Wm. A. Keller	Rexburg

RECEIVED AUG 9 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67032

County of Madison
City of Salem
Registration District No. 100
Primary Registration District No. 2178
(No.)
Local Registrar's No. 58

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Colleen Mortensen.

(a) Residence. No. St. 10
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.M.	White	Babe

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan 16 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	1	6	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salem, Idaho,

PARENTS

10 NAME OF FATHER
LeRoy Mortensen.

11 BIRTHPLACE OF FATHER (city or town) (State or country)
Salem, Idaho,

12 MAIDEN NAME OF MOTHER
Ester Leona Brown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)
Rigby, Idaho,

14 Informant LeRoy Mortensen.
(Address)
Rexburg, Idaho.

15 Filed 7/26, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
(Month) July (Day) 25 (Year) 1929

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1929, to July 25, 1929,
that I last saw h[illegible] alive on July 25, 1929,
and that death occurred, on the date stated above, at 11:00 m.

The CAUSE OF DEATH* was as follows:
Laryngeal Diphtheria
(duration) [illegible] yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) Diphtheria
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible] Rigby, M. D.
July 25, 1929 (Address) [illegible] Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rigby, Idaho,
Date of Burial: 7/26/29
20. Undertaker [illegible] Eckersell
Address Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 9 1929

PLACE OF DEATH

County of Madison

City of Sugar

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

(No. General Hospital Rexburg) 184

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 67033

Local Registrar's No. 57

2. FULL NAME Helen Gamer

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. ..... mos. 4 ds. .....
(If nonresident give city or town and State)
How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds. .....

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 26, 1916

7. AGE — Years: 13 — Months: 3 — Days: 27 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: at school

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Sugar City Madison Co. Idaho

PARENTS

10. NAME OF FATHER: Leonard Garner

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ogden Weber Co. Utah

12. MAIDEN NAME OF MOTHER: Bertha L. Crandall

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Huntington Utah

14. Informant: Lyman Garner
(Address): Sugar City Ida.

15. Filed 7/26 1929 J. Reyong Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to July 22, 1929, that I last saw her alive on July 22, 1929, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows: Haemolytic Streptococci infection, Generalized. Lesions. Accidental Pitch fork Puncture of Left groin region (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. Rigby, M. D.

July 25, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sugar City Ida. — Date of Burial: July 26 1929

20. Undertaker: Wm. J. Keller. — Address: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67034

PLACE OF DEATH
County of ~~Rexburg~~ Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 56

2. FULL NAME Hareyuki Takahashi

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Jap
5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Son K. Takahashi

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 1 | Months 5 | Days 19 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): California

PARENTS
10 NAME OF FATHER: K. Takahashi
11 BIRTHPLACE OF FATHER (city or town) (State or country): Japan
12 MAIDEN NAME OF MOTHER: Y. Takahashi
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Japan

14 Informant: Geo. Kusaka
(Address)

15 Filed 7/20, 1929 J. Ryoming Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July 18 (Month) (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 7-18, 1929, to 7-18, 1929, that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:
Drowning
accidental
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [illegible] Sutherland, M. D.
7-19, 1929 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rexburg Ida
Date of Burial: 7/20 1929

20. Undertaker: A. B. Eckersell
Address: Rexburg

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67035

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 55

PLACE OF DEATH
County of Madison
City of Rexburg
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martha Jane Rea Ace

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July 1st 1863

7. AGE: Years 66 | Months X | Days 15 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): at Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Logan Utah

PARENTS

10. NAME OF FATHER: Thos. E. Ricks
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tennessee
12. MAIDEN NAME OF MOTHER: Elizabeth Jane Sheeps
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14. Informant: Orson A Ricks
(Address): Rexburg Ida.

15. Filed 7/19, 1929 J. K. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16½ (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to July 15, 1929
that I last saw h er alive on July 15, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis,
Chronic Nephritis,
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. B. Craig M. D.
July 18, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rexburg Ida. | Date of Burial: July 18 1929
20. Undertaker: Vern L Keller | Address: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67036

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 54

88 B

2. FULL NAME Margaret Bassett Muir

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Muir

6. DATE OF BIRTH (month, day and year) Sept 26 1859.

7. AGE: 69 Years, Months: 9, Days: 16. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) at Home.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ~~Whales~~ Lickwith Wales

PARENTS

10. NAME OF FATHER Thomas Bassett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~~Whales~~, Wales

12. MAIDEN NAME OF MOTHER Margaret Bassett.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales ~~Whales~~

14. Informant Raymond B. Muir.
(Address) Rexburg, Idaho.

15. Filed 7/17, 1929 J Ryoung Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 9th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1928, to July 4, 1929
that I last saw her alive on July 4, 1929
and that death occurred, on the date stated above, at 4 P.M. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
Chardiac Insufficiency
..... (duration) ..... yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) H B Rigby, M. D.
July 16, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sugar City Ida. Date of Burial: July 12 1929.

20. Undertaker: Vern J. Keller Address: Rexburg

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67037

PLACE OF DEATH
County of Minedoka
City of Rupert
Registration District No. 19
Primary Registration District No. 20/5
Local Registrar's No. 26
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Parley Pratt Parker

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Parker

6. DATE OF BIRTH (month, day and year) Oct. 16 1880

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	9		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hooper Utah

PARENTS

10. NAME OF FATHER Charles Parker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Lorina Robinson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant David Parker
(Address) Rupert Idaho.

15. Filed 7-19, 1929 Ed E Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30, 1929, to July 16, 1929
that I last saw h[illegible] alive on July 25, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Acute nephritis
(duration) unknown yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerotic heart disease with Hypertension
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Urine, B.P. etc
(Signed) Ed E Elmore, M. D.
7-19, 1929 (Address) Rupert,

*State the DISEASE CAUSING DEATH. In deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rupert Ida — Date of Burial July 19 1929

20. Undertaker D.E. Johnson — Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

File No. 67038

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amanda L Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Aug (Month) 20 (Day) 1869 (Year)

7. AGE: 59 Yrs. 11 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Hotel Rooms

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: August Lundberg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amanda Brockie

(Address) Rupert Idaho

15.

Filed ..... 19 .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1929 (Year) 74a

17. I HEREBY CERTIFY, That I attended deceased from July 28 1929, to July 28 1929, that I last saw her alive on July 28 1929 and that death occurred on the date stated above, at 3:10 A M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) about 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) See Reverse side

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leland Frazier M. D.

..... 19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Anthony Idaho

DATE OF BURIAL: Aug 4 1929

20. UNDERTAKER: W. A. Goodman

ADDRESS: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67039

PLACE OF DEATH
County of Minedoka
City of Heyburn

Registration District No. 19
Primary Registration District No. 2015
Local Registrar's No. 28

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Mary L Dawson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Fredrick A Dawson

6. DATE OF BIRTH (month, day and year) Oct 13 1834

7. AGE Years 95 Months 9 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10. NAME OF FATHER Benj~~[illegible]~~ Bayley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Hannah Horr

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vermont

14. Informant Leon A. Dawson
(Address) Heyburn, Idaho

15. Filed 7-28, 1929 E. H. Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 27 1929 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to July 26, 1929
that I last saw her alive on July 26, 1929
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) D. H. E. Dean, M. D.
July 28, 1929 (Address) Twin Schools Bunty Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Half Way Oregon
Date of Burial July 31 1929

20. Undertaker D.E.Johnson
Address J. Bayley

FORM V. S. No. 2-25 M. 1-19

RECEIVED JUL 24 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of Culdesac, R.R. I

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

State File No. 67040

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Noble Henry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Nov. (Month) 18 (Day) 1838 (Year)

7. AGE: 90 Yrs. 7 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF Father: Joseph Henry

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Ann Fisher

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo O Keck

(Address) Lapwai Idaho

15. Filed June 1929 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1927, to June 27 1929, that I last saw him alive on June 26 1929, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. — mos. — ds.

Contributory (Secondary) Gangrene (right foot)

(Duration) 1 yrs. — mos. — ds.

(Signed) Geo O Keck M. D.

6/28 1929 (Address) Lapwai Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jacque Spur

DATE OF BURIAL: 6/29 1929

20. UNDERTAKER: The Family

ADDRESS: Culdesac R.R. I

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 24 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 67041

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce

City of Culdesac Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Louis Brashears

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 70 Yrs. ..... Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Not known

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Brashears
(Address) Culdesac Idaho.

15. Filed June 29 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5—1— 1929, to 6—11— 1929, that I last saw her alive on 6—11— 1929 and that death occurred on the date stated above, at 11.55 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Cholecystitis

(Duration) ..... yrs. 1 mos. 11 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaignard M. D.

6/12/1929 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shekpro Mission — DATE OF BURIAL: 6—13— 1929

20. UNDERTAKER: Brower-Ware — ADDRESS: Lewiston Idaho.

RECEIVED JUL 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67042

PLACE OF DEATH

County of Nez Perce
City of Culdesac Idaho

Registration District No. 128
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Lillie Mae Crow

(a) Residence. No. Culdesac Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. 19 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Crow

6. DATE OF BIRTH (month, day and year) April 29 1872

7. AGE	Years	Months	Days	If LESS than 1 day,
	57	1	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mt. Ayr Iowa

PARENTS

10. NAME OF FATHER John Burks
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Propst
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Vera Murphey
(Address) Culdesac Idaho

15. Filed June 19 29 George Gaigmard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-5, 1928, to 5-9, 1929
that I last saw her alive on 5-9, 1929
and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH was as follows:
Chronic Perenkhymatus Nephritis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. 11 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Albuminuria
(Signed) George Gaigmard M. D.
7/12 1929 (Address) Culdesac Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Culdesac Idaho.	6-12 - 1929
20. Undertaker H R Merchant	Address Clarkston Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 24 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Nez Perce
City of Lapwai
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128
Primary Registration District No.
(No. St.)

State File No. 67043
Local Registrar's No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Delbert Morlan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH: March 5 1878
(Month) (Day) (Year)

7. AGE: 51 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF Father: Jason L Morlan

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Angeline Bird

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. L. Morlan
(Address): Lapwai, Idaho.

15. Filed May 1929 George Gessner
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1929, to May 20 1929, that I last saw him alive on May 20 1929, and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Influenza 4
(Duration) ....yrs. ....mos. ....ds.
Contributory (Secondary): Pulmonary Edema.
(Duration) ....yrs. ....mos. 1 ds.

(Signed) Leo O Keefe M. D.
5/20 1929 (Address) Lapwai, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho
DATE OF BURIAL ....19....

20. UNDERTAKER: Brauer-Wasson
ADDRESS: Lewiston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67044

PLACE OF DEATH
County of Nez Perce
City of Culdesac

Registration District No. 128
Primary Registration District No.
(No. Culdesac)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Julia Sarah Green

(a) Residence. No. Culdesac, St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	80	2	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10. NAME OF FATHER: Alfred Furman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.
12. MAIDEN NAME OF MOTHER: Jerusha Tickner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N. Y.

14. Informant: F. M. Rogers,
(Address) Culdesac, Ida.

15. Filed May, 19 29 George Gaynor Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May, 15, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to ____, 19__
that I last saw h__ alive on ____, 19__
and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:
Senility
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) F. M. Brower Coroner, M. D.
5/16, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Normal Hill, Lewiston, Ida.	5/17/29
20. Undertaker	Address
Brower - Wann Co., Lewiston,	Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67045

PLACE OF DEATH
County of Ney Perce
City of Sweetwater

Registration District No. 128
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Titus Switzler

(a) Residence. No. Sweetwater St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

100a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Indian
5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 4-8-27

7. AGE Years 2 Months 1 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Chas Switzler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oregon
12. MAIDEN NAME OF MOTHER Lidia Henry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Len Henry
(Address) Sweetwater

15. Filed May, 1929 George Gaignard M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-10-, 1929, to 5/9/29, 19
that I last saw him alive on 5/9-, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Brontho-Pneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) George Gaignard, M. D.
May, 1929 (Address) Culdesac Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sweetwater
Date of Burial 19

20. Undertaker Family
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67046

PLACE OF DEATH

County of Nez Perce
City of Sweetwater
Registration District No. 128
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harry Eatmon

(a) Residence. No. Sweetwater St. 101A
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 22, 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	11	4	12	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER J. W. Eatmon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina
12. MAIDEN NAME OF MOTHER Sarah Tipton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14. Informant M. Y. Eaton
(Address) Lewiston

15. Filed April, 1929 George Gaigmard
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21, 1929, to April 21, 1929
that I last saw him alive on April 21, 1929
and that death occurred, on the date stated above, at 3:00 A m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(duration) yrs. mos. 24 hours ds.
CONTRIBUTORY (Secondary) Purulent Cerebro-Spinal Meningitis
(duration) yrs. mos. 24 hours ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Pus in Spinal Fluid

(Signed) George Gaigmard, M. D.
April, 1929 (Address) Culdesac Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho. Normal Hill	4/24/29 19

20. Undertaker	Address
Brower - Wann Co.	Lewiston

FORM V. S. No. [illegible] RECEIVED JUL 24 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of Lapwai

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

State File No. 67047

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliza Ellen Travis, Wa

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word)

6. DATE OF BIRTH: June (Month) 23 (Day) 1863 (Year)

7. AGE: 65 Yrs. 9 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF Father: Mathew B. Acree

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: May Matilda Rowlett

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. S. A. Skinner
(Address) Lapwai Idaho

15. Filed April 1929 George Gaignard M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1929, to April 10 1929, that I last saw her alive on April 9 1929, and that death occurred on the date stated above, at 1:40 a. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo O Keck M. D.

Apr 10 1929, (Address) Lapwai, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston

DATE OF BURIAL: 4/12/1929

20. UNDERTAKER: J. R. Merchant

ADDRESS: Clarkston Wa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 25 M. 1-24 RECEIVED JUL 24 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of Lapwai

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

State File No. 67048

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Allen Russell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: April (Month) 4 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Lapwai Idaho

10. NAME OF Father: Wm W. Russell.

11. BIRTHPLACE OF FATHER (State or Country): Madera California

12. MAIDEN NAME OF MOTHER: Mabel Brown

13. BIRTHPLACE OF MOTHER (State or Country): Portland, Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo O Keck

(Address) Lapwai Idaho

15.

Filed April - 1929 George Gasgnard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1929, to April 6 1929, that I last saw him alive on April 5 1929, and that death occurred on the date stated above, at 3a. M.

The CAUSE OF DEATH* was as follows:

Monstrosity.
(Born with brain outside of skull)

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo O Keck M. D.

4/7 1929 (Address) Lapwai, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spalding Idaho

DATE OF BURIAL: 4/6 1929

20. UNDERTAKER: The Family.

ADDRESS: Lapwai Ida.

Gaignard

RECEIVED JUL 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6705O

PLACE OF DEATH

County of Nez Perce.

City of Lapwai.

Registration District No. 128

Primary Registration District No.

(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert Thomas Miller.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	Indian.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 14th, 1911.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18.	2.	8.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Ahsahka,
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Thomas Moses Miller.

11. BIRTHPLACE OF FATHER (city or town) Lapwai,
(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Mary Marks.

13. BIRTHPLACE OF MOTHER (city or town) Aksahka,
(State or Country) Idaho.

14. Informant Mrs Silas Whitman.

(Address) Lapwai, Idaho.

15. Filed March, 1929. George Gaignard M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 22nd, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
3-8-, 1929, to 3-22-, 1929
that I last saw h alive on 3-22-, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George Gaignard, M. D.
3/24/29. 19 (Address) Culdesac, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spalding, Idaho.	3/24/29. 19

20. Undertaker	Address
Brower-Mann Company.	Lapwai, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67051

PLACE OF DEATH

County of Nez Perce.

City of Webb.

Registration District No. 128

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Keck Mayo.

(a) Residence. No. St. Webb, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

161a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 16th, 1929.

7. AGE Years: ------ Months: ----- Days: 6. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Webb, Idaho.

PARENTS

10. NAME OF FATHER Robert J. Mayo.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~~Lewx~~ Idaho.

12. MAIDEN NAME OF MOTHER Ora DePartee,

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Orofino, Idaho.

14. Informant A. J. Gustin.
(Address) Webb, Idaho.

15. Filed March, 1929. George Gaugnard M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 22nd, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16, 1929, to March 22, 1929 that I last saw her alive on March 20, 1929 and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth (7 month baby)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. O. Keck, M. D.

3/22/29., 19 (Address) Lapwai, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 3/22/29. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho

FORM V. S. No. 5-25 M. 1-19

RECEIVED JUL 24 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 67052

1. PLACE OF DEATH
County of Nez Perce
City of Culdesac Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128
Primary Registration District No.
(No. ..... St.)

Local Registrar's No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Albert Stewart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widowed

6. DATE OF BIRTH: August (Month) 20 (Day) 1841 (Year)

7. AGE: 87 Yrs. 6 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF Father: William Stewart

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER: Sarah Swarthout

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Arlie George
(Address) Culdesac Idaho

15. Filed March 14 – 1929 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 – 1929 to March 12 1929
that I last saw him alive on March 10 – 1929,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) ..... yrs. ..... mos. 8 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) George Gaignard M. D.
3/12/1929 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Culdesac Idaho	March 13 1929
20. UNDERTAKER	ADDRESS
H. K. Merchant	Clarkston Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67053

PLACE OF DEATH

County of Nez Perce.
City of Spalding.
Registration District No. 128
Primary Registration District No.
Local Registrar's No.

(No. 115 (B))
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nellie Huie.

(a) Residence. No. St. Spalding, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	Chinese.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1/20/1929.

7. AGE Years	Months	Days	If LESS than 1 day,
---	1.	21.	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spalding, Idaho.

PARENTS

10. NAME OF FATHER Ning Huie.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) China.
12. MAIDEN NAME OF MOTHER Lim See.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) China.

14. Informant Ning Huie
(Address) Spalding, Idaho.

15. Filed March 1929 George Gasmann Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 11th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11, 1929, to March 11, 1929
that I last saw her alive on March 11, 1929
and that death occurred, on the date stated above, at 11:30 P. m.
The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Ted O Keefe, M. D.
3/13/29., 19 (Address) Lapwai, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	3/13/29. 19
20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

1. PLACE OF DEATH

RECEIVED AUG 6 1929

County of Oneida Registration District No. 26

City of Malad. Primary Registration District No. 2069

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

State of Ohio
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 67054

Registered No. 20

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stephen Dale Stayner

The information on this certificate is an exact COPY of the official certificate at place of death.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX. Male

4. COLOR OR RACE. White

5. Single, Married, Widowed or Divorced. Single (Write the Word.)

6. DATE OF BIRTH Sept - 8 - 1913 (Month) (Day) (Year)

7. AGE. 15 Yrs. 9 Mos. 29 ds.

IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION.
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE. (State or Country) Fielding Ut.

10. NAME OF FATHER Steve Stayner

11. BIRTHPLACE OF FATHER (State or Country) Fielding Ut.

12. MAIDEN NAME OF MOTHER Catherine Daniels

13. BIRTHPLACE OF MOTHER (State or Country) Malad Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Steve Stayner
(Address) Malad Ida

15. Filed 7/31, 1929 J. M. Kerns
Local Registrar.

Place Where Remains are to be Sent

Date of Shipment ....., 191...

SHIPPING UNDERTAKER

ADDRESS ..... Firm Name .....

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July - 14, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11, 1929 to July 14, 1929 that I last saw him alive on July 14, 1929 and that death occurred on the date stated above, at 4 a M.

The CAUSE OF DEATH was as follows:
Epidemic Spinal meningitis

..... (Duration) ..... Years ..... mos. 4 ds.

Contributory (Secondary.) .....

..... (Duration) ..... Years ..... mos. ..... ds.

Signed O. H. Mabey M. D.

7/15, 1929 (Address) Malad Idaho

* State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)

At place ..... in the .....

of death ..... yrs. ..... mos. ..... days State ..... yrs. ..... mos. ..... days

Where was disease contracted

if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Malad Ida

Date of Burial July 15, 1929

20. UNDERTAKER J. Guy Benson

Address Malad Ida.

PLACE OF DEATH RECEIVED AUG 6 1929

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

County of Oneida

City of Malad.

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 2069

(No. Community Hospital St.)

2. FULL NAME Evan Crosby

File No. 67055

Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

The information on this certificate is an exact COPY of the official certificate at place of death.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX. Male

4. COLOR OR RACE. White

5. Single, Married, Widowed or Divorced. Single (Write the Word.)

6. DATE OF BIRTH. Jan. 10 1910 (Month) (Day) (Year)

7. AGE. 19 Yrs. 6 Mos. 4 ds. IF LESS than 1 day, how many.....hrs. or .....min.?

8. OCCUPATION.
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE. (State or Country) Panguitch Utah.

10. NAME OF FATHER Edward W. Crosby

11. BIRTHPLACE OF FATHER (State or Country) Nev.

12. MAIDEN NAME OF MOTHER Etta May Floyd.

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward W. Crosby
(Address) Mt Emmons Ut

15. Filed 7/31, 1929 J. M. Tarus Local Registrar.

Place Where Remains are to be Sent | Date of Shipment ....., 191...

SHIPPING UNDERTAKER

ADDRESS.....Firm Name.....

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 14, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929 to July 14, 1929 that I last saw him alive on July 14, 1929 and that death occurred on the date stated above, at 5A M.

The CAUSE OF DEATH was as follows:

Peritonitis

(Duration) ..... Years ..... mos. 14 ds.

Contributory (Secondary.) Rupture app.

(Duration) ..... Years ..... mos. 21 ds.

Signed J. H. Mabey M. D.

July 15, 1929 (Address) Malad Idaho

* State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)

At place.....in the.....

of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted

if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mt. Emmons Ut. | Date of Burial July 17 1929

20. UNDERTAKER J. Guy Benson | Address Malad Idaho

PLACE OF DEATH

RECEIVED AUG 6 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

County of Oneida — Registration District No. 26

City of Malad — Primary Registration District No. 2069

File No. 67056

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David L. Evans

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced. (Write the Word.): Married.
6. DATE OF BIRTH: May (Month) 20 (Day), 1854 (Year)
7. AGE: 75 Yrs. 1 Mos. 22 ds. IF LESS than 1 day, how many ..... hrs. or ..... min.?
8. OCCUPATION. (a) Trade, profession or particular kind of work: Barber (b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE. (State or Country): Brigham City Utah.
10. NAME OF FATHER: David R. Evans
11. BIRTHPLACE OF FATHER (State or Country): Wales.
12. MAIDEN NAME OF MOTHER: Winnifred Lloyd.
13. BIRTHPLACE OF MOTHER (State or Country): S. Wales
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. L. Evans
(Address) Malad Ida
15. Filed 7/31, 1929 J. M. Kress Local Registrar.

Place Where Remains are to be Sent | Date of Shipment ....., 191...

SHIPPING UNDERTAKER

ADDRESS ..... Firm Name .....

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 12 (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1929, to July 12, 1929, that I last saw him alive on July 11, 1929 and that death occurred on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH was as follows:

Myocarditis.

(Duration) 3 Years ..... mos. ..... ds.

Contributory (Secondary.) Parkinsons disease,

(Duration) 7 Years ..... mos. ..... ds.

Signed V. P. Grant M. D.

July 13, 1929 (Address) Malad, Ida.

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)

At place ..... in the .....

of death ..... yrs. ..... mos. ..... days State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? —

Former or usual residence Malad, Ida

19. PLACE OF BURIAL OR REMOVAL: Malad Ida — Date of Burial: July 14, 1929

20. UNDERTAKER: J. Guy Benson — Address: Malad Ida.

The information on this certificate is an exact COPY of the official certificate at place of death.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 87057
Registered No. 17

1. PLACE OF DEATH
County of Ontario
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Erastus Nelson Wells.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Nov. (Month) 30 (Day) 1910 (Year)

7. AGE: 18 Yrs. 7 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad Ida.

10. NAME OF FATHER: Lawrence R. Wells.

11. BIRTHPLACE OF FATHER (State or Country): Woodruff Utah

12. MAIDEN NAME OF MOTHER: Annie Bell.

13. BIRTHPLACE OF MOTHER (State or Country): Malad Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lawrence R Wells
(Address) R.D.#2 Malad Ida.

15. Filed 7/31 1929 J. M. Nevs
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1929 to July 9 1929 that I last saw h- alive on July 9 1929 and that death occurred on the date stated above, at 7:05 M.

The CAUSE OF DEATH* was as follows:
Tbc Cerebrospinal
Meningitis

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Mabey M. D.
7/9 1929 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Ida. DATE OF BURIAL: July 11 1929

20. UNDERTAKER: J. Guy Benson ADDRESS: Malad Ida.

FORM V. S. No. 525 M.D.

RECEIVED AUG 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida

City of Malad

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 06

Primary Registration District No. 2069

(No. ..... , ... St.)

File No. 67058

Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Beeton Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 14 (Day) 1870 (Year)

7. AGE: 58 Yrs. 8 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: William Beeton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hanner Gerner

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lloyd Beeton

(Address) Malad Ida. R.F.D.

15. Filed 7/31 1929 J. M. Kerns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1929, to July 2 1929 that I last saw him alive on July 1 1929 and that death occurred on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows: Mitral Reg + Stenosis

..... (Duration) ..... Yrs. 8 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

7/3 1929 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Deweyville Utah

DATE OF BURIAL: July 1929

20. UNDERTAKER: Deseret Mortuary

ADDRESS: Brigham Co.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 2669
File No. 67059
Registered No. 23

1. PLACE OF DEATH

County of Oneida
City of Malad
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Khalid Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: July (Month) - 16 (Day) 1914 (Year)

7. AGE: 15 Yrs. ..... Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad Idaho

10. NAME OF FATHER: Thomas R. Williams

11. BIRTHPLACE OF FATHER (State or Country): Malad Idaho

12. MAIDEN NAME OF MOTHER: Mary A. Daniels

13. BIRTHPLACE OF MOTHER (State or Country): Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. T. K. Williams
(Address) .....

15. Filed 7/31 1929 J. M. Knows
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) - 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1929, to July 21, 1929, that I last saw h[illegible] alive on July 21, 1929, and that death occurred on the date stated above, at 1.30 A.M.

The CAUSE OF DEATH* was as follows:
Cerebro-spinal meningitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. O. Garst M. D.
July 21, 1929 (Address) Malad, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: July 22 1929

20. UNDERTAKER: J. Levy Herman — ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 2069
File No. 67060
Registered No. 22

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sale Emma Sorenson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: Sept (Month) 16 (Day) 1925 (Year)

7. AGE: 3 Yrs. 10 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad Idaho

10. NAME OF FATHER: Golden L. Sorenson

11. BIRTHPLACE OF FATHER (State or Country): Hyrum Utah.

12. MAIDEN NAME OF MOTHER: Dore Blaindell

13. BIRTHPLACE OF MOTHER (State or Country): Centerville Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Golden L. Sorenson
(Address) Malad Idaho

15. Filed 7/31 1929 J. M. Evans Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to 4 hours 19.....
that I last saw h.er alive on July 17 1929
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Epidemic Spinal Meningitis
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M. D.
7/19 1929 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Cem
DATE OF BURIAL: July 18 1929

20. UNDERTAKER: J. Guy Benson
ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 5 1929

CERTIFICATE OF DEATH

Registration District No. 26

Primary Registration District No. 2069

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 67061

Registered No. 71

1. PLACE OF DEATH

County of Oneida

City of Stone Dr

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Lucinda Pack

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 21 (Day) 1860 (Year)

7. AGE: 68 Yrs. 8 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alabama.

10. NAME OF FATHER: Wm C Moody

11. BIRTHPLACE OF FATHER (State or Country): Texas Alabama

12. MAIDEN NAME OF MOTHER: Eliza Bess

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm C Pack

(Address) Snowville Utah

15. Filed 7/31 1929

J. M. Kerns
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1929 to July 15 1929

that I last saw h.. alive on July 15 1929

and that death occurred on the date stated above, at 2 40 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart & Paralysis following operation.

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Carcinomata.

(Duration) 7 yrs. ..... mos. ..... ds.

(Signed) C W Sandleigh M. D.

7/17 1929 (Address) Snowville Utah

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Snowville Utah — DATE OF BURIAL: July 18 1929

20. UNDERTAKER: Guy Benson — ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 3 1929

PLACE OF DEATH RECEIVED SEP 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67062

County of Owyhee
City of Melba

Registration District No. 107
Primary Registration District No. 2185
(No. .....)

Local Registrar's No. 1

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mary Elizabeth Young 1205a

(a) Residence. No. Melba Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: C F Young

6 DATE OF BIRTH (month, day and year): Nov 30 1867

7 AGE: Years 61 | Months 5 | Days 16 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Missouri

PARENTS
10 NAME OF FATHER: M Martin
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: Hatfield
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: W V Young
(Address) Huston #1 Ida

15 Filed May 18, 1929 Robert E Talbot Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 16 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Pneumonia & Kidneys

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) ....., M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Knowlton Hights
Date of Burial: 5/17 1929

20. Undertaker: C V Peckham
Address: Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 2 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

R. E. Talbot
Wilder, Idaho

[redacted]

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

E. K. Macy

Special Agent, Bureau of Census.

In reference to the death certificate of:

Mary Elizabeth Young who died at Melba, Idaho on May 16, 1929

Information DESIRED in order to complete certificate.

Cause of death.
We are enclosing the certificate. Will you please have the attending physician sign the same?
PLEASE ANSWER BELOW no MD attended this case.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1929

PLACE OF DEATH

County of Owyhee

City of King Hill

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 74

Primary Registration District No. 2151

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67063

Local Registrar's No. 48

2. FULL NAME Russell Edward Wagner

(a) Residence. No. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 27, 1923

7. AGE 6 Years 10 Months 25 Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) King Hill, Idaho

PARENTS

10. NAME OF FATHER John R. Wagner

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denver, Colo.

12. MAIDEN NAME OF MOTHER Mildred Ella Byrum

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Boulder, Colo.

14. Informant Mrs. John Wagner

(Address) King Hill, Idaho

15. Filed Aug. 3, 1929 W J Aberbuck Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 1st (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH* was as follows:

accidental fall 50 feetdown cliff

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W J Aberbuck, M. D.

Aug. 2, 1929 (Address) Grand View

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gleens Ferry	Aug. 2 1929
20. Undertaker C. G. Zacher	Address Mt Home

RECEIVED AUG 3 1929

PLACE OF DEATH

County of Power

City of American Falls, Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 29-
Primary Registration District No. 2072

DO NOT WRITE IN THIS SPACE
State File No. 67064

Local Registrar's No. 21

(No. 128)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Graff

(a) Residence. No. (Usual place of abode) St. Johnstown, Neb (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Graff

6. DATE OF BIRTH (month, day and year) Nov 15t 1852

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
76	7	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N.Y.

PARENTS

10. NAME OF FATHER David Graff

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant C. H. Graff

(Address) Mount Vernon Wash R.F.D. 2,

15. Filed 7-12, 1929 Jessie Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7. (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1929, to July 12, 1929 that I last saw h 10 o'clock alive on July 12, 1929 and that death occurred, on the date stated above, at July 12 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V. G. Logan, M. D.

7/12/29, 19 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Grand Prairie,	
20. Undertaker Johnstown, Neb Aw Davis	Address Am Falls, Ida

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 3 1929

PLACE OF DEATH

County of Power

City of American Falls, Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 21

Primary Registration District No. 2072

DO NOT WRITE IN THIS SPACE

State File No. 67065

Local Registrar's No. 20

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles McKee Travelute 162

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 5 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 22nd 1914

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	4	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Deadwood S.D.

PARENTS

10. NAME OF FATHER Clark Travelute

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kans

12. MAIDEN NAME OF MOTHER Kathryn Lawrenson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mont

14. Informant Kathryn Travelute

(Address) American Falls, Idaho

15. Filed 7-12, 19 Genevieve Nolte Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 10 (Day) 19 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Drowned in American Falls, Lake. He had a sale on a light boat, and it is beleived the boom struck him on the head, and upsetting the boat

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. W. Davis Coroner

7/12/29, 19 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Marysville, Kans	
20. Undertaker A. W. Davis	Address American Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67066

PLACE OF DEATH
County of Shoshone.
City of Wallace
Registration District No. 20
Primary Registration District No. 1911
Local Registrar's No. 25
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah A Kingsley

(a) Residence. No. Mullan Idaho St. Mullan, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White.	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of George Kingsley.

6. DATE OF BIRTH (month, day and year) March 26 - 1885

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	3	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mich.

PARENTS

10. NAME OF FATHER Richard Wallace
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER — Connor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant George Kingsley
(Address) Mullan, Idaho.

15. Filed June 30, 1929. F. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1929, to June 27 1929
that I last saw h~~er~~ alive on June 27 1929
and that death occurred, on the date stated above, at 1140 p.m.

The CAUSE OF DEATH* was as follows:

Paralysis of Heart
Probable Apoplexy
(Duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(Duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Dr. H. Wagner, M.D.
6/28, 1929 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mullan, Idaho.	June 30 1929

20. Undertaker J. A. Bever Ward Undertaking Co. Address Wallace, Idaho

569

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67067

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 74

66

2. FULL NAME Anthony Ryan

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, ... hrs. or ..... min.
About 45

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10. NAME OF FATHER Peter Ryan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland.

14. Informant Frank Nelis.
(Address)

15. Filed June 29, 1929 T. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22, 1929, to June 26, 1929
that I last saw him live on June 26, 1929
and that death occurred, on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Encephalitis alcoholic
Delirium Tremens
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) alcoholism & Chr
..... (duration) Several yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Dr. Mowery, M. D.
6/27, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal New York City, N.Y. Date of Burial Shipped June 1929

20. Undertaker J. R. Bever Ward Undertaking C. Address Wallace Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

8

RECEIVED JUL 18 1929

PLACE OF DEATH

County of Shoshone

City of Wallace

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67068

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 73

(No. Providence, Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74B

2. FULL NAME Dorsey McKinney

(a) Residence. No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Edna McKinney.

6. DATE OF BIRTH (month, day and year) Apr 17 - 1898

7. AGE Years 31 Months 2 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Joplin Mo.

PARENTS

10. NAME OF FATHER Robt. McKinney.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Mary Dorsey.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Hans McKinney.
(Address) Wallace, Idaho.

15. Filed June 29, 1929 T. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 16, 1929 to June 25, 1929 that I last saw him alive on June 25, 1929 and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Embolism heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

Double Empyema (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/30

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) Dr. H. McWhorter, M. D.

6/27, 1929 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial June 29 1929

20. Undertaker J. A. Bever Ward Undertaking Co. Address Wallace, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Kennedy

RECEIVED JUL 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67069

PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 10

Primary Registration District No. 10-11

Local Registrar's No. 72

(No. Residence.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Kennedy. 90

(a) Residence. No. Wallace, Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Altha Kennedy.

6. DATE OF BIRTH (month, day and year) Sept. 2 - 1854

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	7	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired.

9. BIRTHPLACE (city or town) (State or country) Nova Scotia

PARENTS

10. NAME OF FATHER Alexander Kennedy.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland.

12. MAIDEN NAME OF MOTHER Katherine McKissick

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland.

14. Informant Mrs Altha Kennedy.

(Address)

15. Filed June 26, 1929 J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1928, to June 22, 1929 that I last saw h[illegible] alive on June 22, 1929 and that death occurred, on the date stated above, at 5:10 P m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James R Bean, M. D.

6/22/29 19 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hope, Idaho.	June 26 1929

20. Undertaker J. A Bower Address

Ward Undertaking Co. Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Chandler

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67070

PLACE OF DEATH
County of Shoshone
City of Wallace.

Registration District No. 70
Primary Registration District No. 10 11
(No. Residence.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 71

2. FULL NAME James Oscar Chandler 31

(a) Residence. No. Wallace, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Daisy A Chandler.

6. DATE OF BIRTH (month, day and year) July 28- 1877

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	10	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER John C Landler

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Marah Barr

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs James C Landler
(Address) Wallace, Idaho.

15. Filed June 24, 1929. T. L. Lewis Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1929 to June 22, 1929
that I last saw him alive on June 22 1929
and that death occurred, on the date stated above, at 3.50 P m.
The CAUSE OF DEATH* was as follows:

Pneumonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Silicosis

(duration) 4 years yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) James R Bean, M. D.
6/27/29 19 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho.	June 24 1929
20. Undertaker J. G. Boyer Ward Undertaking Co.	Address Wallace, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67071

PLACE OF DEATH
County of Shoshone
City of

Registration District No. 70
Primary Registration District No. 1614
(No. Northfork district)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 70

2. FULL NAME Ben Carrigan

(a) Residence. No. Ensaville, Idaho St. Ensaville, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 4 - 1899

7. AGE

Years	Months	Days	If LESS than 1 day,
29	7	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hopkins Bros.

9. BIRTHPLACE (city or town) (State or country) Spokane Wn.

PARENTS

10. NAME OF FATHER Ben Carrigan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Louise Michelson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland.

14. Informant Mrs Ben Carrigan
(Address) Ensaville Idaho.

15. Filed June 23, 1929 J. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 12:30 P m.
The CAUSE OF DEATH* was as follows: Crushed & broke Neck & Back Accidentally fell from log
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible] Morgan Cor. D.
6/21, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg	June 23 1929
20. Undertaker J. H. Boyer Wallace Idaho	Address Wallace Ida

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. 1. 5-25 M. 1-19.

RECEIVED JUN 12 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 67072

Local Registrar's No. 69

1. **PLACE OF DEATH**

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1911

(No. Providence Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Margarete Jane Spencer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6. **DATE OF BIRTH** July (Month) 30 (Day) 1871 (Year)

7. **AGE** 57 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Boarding House

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Joplin Mo.

10. **NAME OF Father** Sahford Copple

11. **BIRTHPLACE OF FATHER** (State or Country) Mo.

12. **MAIDEN NAME OF MOTHER** Elizabeth Copple

13. **BIRTHPLACE OF MOTHER** (State or Country) MO

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Roscoe Spencer

(Address) Wallace Idaho

15. Filed June 24 1929 J. L. Quigley Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** June (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1929. to June 19 1929.

that I last saw her alive on June 19 1929.,

and that death occurred on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Crushed by being struck by automobile

(Duration) yrs. mos. 2 ds.

Contributory (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Dr. M. D.

6/21/29 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** I.O.O.F. Cemetery Wallace — **DATE OF BURIAL** 6/24 1929

20. **UNDERTAKER** Worstell Co J. S. Shaughnessy — **ADDRESS** Wallace

very important. See instructions on back of certificate.

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67073

PLACE OF DEATH
County of Shoshone
City of Infirmary

Registration District No. 10
Primary Registration District No. 10 11
Local Registrar's No. 68

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME John Hazeltine

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: miner +
(b) General nature of industry, business, or establishment in which employed (or employer): Prospector
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: Ed Hazeltine
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wisconsin
12. MAIDEN NAME OF MOTHER: Mary Mulcher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Arthur Hazeltine
(Address): Great Falls Mont

15. Filed June 26, 1929. P.O. Box 1077 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1929, to June 10, 1929
that I last saw ~~him~~ alive on June 10, 1929
and that death occurred, on the date stated above, at 4:00 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

6/19, 1929 (Signed) James L Bean, M. D.
(Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Idaho	June 16 1929

20. Undertaker: M. C. Thornhill — Address: Kellogg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 18 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67074

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 10
Primary Registration District No. 1011
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 67

129

2. FULL NAME Carrie May Kelly

(a) Residence. No. Wallace, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fred Kelly

6. DATE OF BIRTH (month, day and year) May 31-1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	0	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) California

PARENTS
10. NAME OF FATHER Whitton Marple
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.
12. MAIDEN NAME OF MOTHER Elizabeth Silberthorn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Chas. Marple
(Address) Wallace, Idaho

15. Filed June 20, 1929. F. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 to June 18, 1929
that I last saw him alive on June 17, 1929
and that death occurred on the date stated above, at 5:30 P.M.
The CAUSE OF DEATH was as follows:
Nephritis Chr
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible] M. D.
6/19, 1929 Address Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	June 20 1929
20. Undertaker J. A. Bever	Address
Ward Undertaking Co.	Wallace Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67075

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1911
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 66

2. FULL NAME Herbert Martin Cavanaugh. 118B

(a) Residence. No. Canyon Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov - 12 - 1922

7. AGE Years 6 Months 7 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS

10. NAME OF FATHER John Cavanaugh
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Alice Cyr.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mont

14. Informant John Cavanaugh
(Address) Wallace Idaho.

15. Filed June 20, 1929. J. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....
that I last saw him alive on June 17, 1929
and that death occurred, on the date stated above, at 7:30 A.M.
The CAUSE OF DEATH* was as follows: Intestinal Obstruction

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Appendicitis Chr. Severe
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? Date of June 17
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Dr. Mowery, M. D.
6/19, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial June 20 1929

20. Undertaker J. A. Bever Ward Undertaking Co. Address Wallace Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67076

PLACE OF DEATH

County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1911
(No. Wallace Hospital) 31
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 65

2. FULL NAME Hugh Gilmour

(a) Residence. No. Mullan, Idaho St. Mullan, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Male
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
~~WIFE of~~ HUSBAND of (or) Agnes Gilmour

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	7	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Federal Mng. Co.

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS
10. NAME OF FATHER Hugh Gilmour
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland.
12. MAIDEN NAME OF MOTHER Jean Friday.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland.

14. Informant Mrs Agnes Gilmour
(Address) Mullan, Idaho.

15. Filed June 16, 1929. E. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to June 13, 1929
that I last saw h~~im~~ alive on June 13, 1929
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) T. C. Wetrich M. D.
June 14, 1929 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mullan, Idaho	June 16 1929
20. Undertaker J. A. Bower	Address
Ward Und Co.	Wallace Idaho

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67077

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. Residence
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 64

31

2. FULL NAME Eleanor Armani

(a) Residence. No. 928 Residence St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 23 - 1912

7. AGE Years 17 Months 1 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEA[redacted]
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10. NAME OF FATHER Louise Armani
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Austria
12. MAIDEN NAME OF MOTHER Marie Tavellie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant Miss Pauline Armani
(Address) Wallace, Idaho.

15. Filed June 14, 1929. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1929 to June 12, 1929
that I last saw her alive on June 11, 1929
and that death occurred, on the date stated above, at 1-10 A m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Intestinal tuberculosis

(duration) ..... yrs. 4 mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) James R Bean, M. D.
6/12/29, 19.. (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial June 14 1929

20. Undertaker J. A. Bever Ward Mfg. Co. Address Wallace, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67078

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 63

74A

2. FULL NAME Maurice Marshall

(a) Residence. No. Buck Road St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1859

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER Don't Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14. Informant
(Address)

15. Filed June 13, 1929 T. K. Quigley (Registrar)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1929 to June 10, 1929
that I last saw him alive on June 10 1929
and that death occurred, on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) years yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) James R. Crain, M. D.
6/11/29, 19 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho.	June 13 1929
20. Undertaker R. P. Stout	Address Kellogg, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 18 1929

PLACE OF DEATH

County of Shoshone

City of Burke

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67079

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 62

(No. Residence.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mike Shea

(a) Residence. No. Burke Idaho St. Burke Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year)

7. AGE 76 Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ritiered Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10. NAME OF FATHER Not Known.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Not Known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Jim Dougherty

(Address) Wallace Idaho

15. Filed June 13, 1929 T. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw him alive on , 19

and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:

Heart failure

(duration) yrs. mos. ds. Instant

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds. Several

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

6/9 (Signed) H. R. Mowry Corony M.D.

, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace Idaho. Date of Burial June 13 1929

20. Undertaker J. A. Bruen Ward Undertaking Co. Address Wallace Idaho

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67080

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1014
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 61

205-a

2. FULL NAME Edith E Jones
(a) Residence. No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Urban E Jones

6. DATE OF BIRTH (month, day and year) Feb 14 - 1875

7. AGE 54 Years | Months 3 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wash

PARENTS
10. NAME OF FATHER Ruben Morgan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Evangeline Harris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mr U. E Jones
(Address) Wallace, Idaho

15. Filed June 7, 1929 S. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to June 5, 1929
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 2:15 P.m.
The CAUSE OF DEATH* was as follows:
Acute Obstruction of Ileum
..... (duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of June 3 - 1929
Was there an autopsy? no
What test confirmed diagnosis? Of findings
(Signed) Max T. Bunce M. D.
6/7/29, 19.... (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho | Date of Burial June 7 1929

20. Undertaker J. A. Beer Ward Undertaking Co. | Address Wallace, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67081

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 60

2. FULL NAME John P. Pauline

(a) Residence, No. Mullan, Idaho St. Mullan, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ellen Pauline

6. DATE OF BIRTH (month, day and year) Oct. 7. 1902

7. AGE

Years	Months	Days	If LESS than 1 day,
26	8	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Millman
(b) General nature of industry, business, or establishment in which employed (or employer) Federal Mng. Co.
(c) Name of employer Morning Mine.

9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS

10. NAME OF FATHER Frank Pauline
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Austria
12. MAIDEN NAME OF MOTHER Johanna Koshier
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Austria.

14. Informant John M Jackson
(Address) Mullan Idaho

15. Filed June 14. 1929 L. K. Lundy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to June 4, 1929
that I last saw him alive on June 4, 1929
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:

Mastoiditis - left
(duration) yrs. mos. 19 ds.
CONTRIBUTORY (Secondary) Lateral sinus thrombosis
(duration) yrs. mos. 9 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of May 15 1929
Was there an autopsy? No
What test confirmed diagnosis? Findings at operation
(Signed) Arthur C Jordan, M. D.
June 6, 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gilbert Minn.	June 14 1929
20. Undertaker J. A. Brewer Ward Undertaking Co.	Address Wallace Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. RECEIVED JUL 18 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 67082

Local Registrar's No. 54

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. Providence Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Isabelle Knudson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH: May (Month) 3 (Day) 1888 (Year)

7. AGE: 41 Yrs. 1 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Sauk Center Minn.

10. NAME OF Father Lars Larson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Isabelle Morian

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs F.J. Smyth

(Address) Cambrook B.C.

15. Filed June 6 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 1928 to June 4 1929

that I last saw her alive on June 3 1929

and that death occurred on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Duration) Several yrs. mos. ds.

Contributory (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Des Mowrey M.D.

6/4 1929 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: KofP Plot Wallace Ida.

DATE OF BURIAL: 6/6/29 19

20. UNDERTAKER: Worstell Co [signature]

ADDRESS: Wallace Lda

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 3 1929

PLACE OF DEATH

County of Shoshone

City of Enaville

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 123

Primary Registration District No. 2201

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 67083

Local Registrar's No. 56

90

2. FULL NAME Sophia Hartman

(a) Residence. No. Sofia St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 15 – 1865

7. AGE: Years 64 | Months 2 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Finland

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Finland

PARENTS

10. NAME OF FATHER: Fredrick Santti

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Mary Santti

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Finland

14. Informant: Santti Santti
(Address)

15. Filed July 30, 1929. Mrs. Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jul (Month) 21 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw her alive on ....., 19.....

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Heart Disease

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Myocarditis Chr

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Mowery Corone

7/23, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kingston Ida

Date of Burial: July 24 1929

20. Undertaker: R. L. Stout

Address: Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1929

PLACE OF DEATH

County of Shoshone

City of Kellogg

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67084

Registration District No. 123

Primary Registration District No. 2201

Local Registrar's No. 35

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Joonas Virtineus

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Do not know

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years about 45 | Months — | Days — | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) no inf.

PARENTS

10. NAME OF FATHER no inf.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) no inf.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) no inf

14. Informant Ron Hooper
(Address) Kellogg, Idaho

15. Filed July 30, 1929. Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Heart disease apparently

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Chr. severe

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. S. Mowery Coroner

7/10, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Ida | Date of Burial July 18 1929

20. Undertaker M. C. Thornhill | Address Kellogg, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67085

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 34

2. FULL NAME Charles Anderson 90

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE: Years 45; Months —; Days —; If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sawmill Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): unknown

PARENTS
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Milton Lumber Co.
(Address) Rose Lake Idaho

15. Filed July 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred on the date stated above, at 2:07 m.
The CAUSE OF DEATH* was as follows: Heart Failure
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) M. C. Mowery Coroner
, 19 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rose Lake Idaho — Date of Burial: June 28 1929
20. Undertaker: M. C. Trumbull — Address: Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

PLACE OF DEATH

County of Teton

City of Driggs

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 77

Primary Registration District No. 2176

(No. 161A)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67086

Local Registrar's No. 2

2. FULL NAME

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 6 — 14 — 1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Driggs, Idaho.

PARENTS

10. NAME OF FATHER J. S. Kimball

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Driggs, Ida.

12. MAIDEN NAME OF MOTHER Dora Bailer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New Mexico

14. Informant J. S. Kimball

(Address) Driggs, Idaho

15. Filed 7 — 1 —, 1929 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 — 14 — 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to June 14, 1929

that I last saw h alive on —, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature birth caused from accident to mother (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. L. Parkinson, M. D.

6 — 15 —, 1929 (Address) Driggs, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Driggs, Idaho	6 — 15 — 1929

20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67087

PLACE OF DEATH
County of Teton
City of Driggs

Registration District No. 77
Primary Registration District No. 2176
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. Three

161a

2. FULL NAME Joyce Hillman
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) June 29th 1929

7. AGE Years | Months | Days 1 | If LESS than 1 day, 18 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Driggs Idaho

PARENTS

10. NAME OF FATHER: Roy L. Hillman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pleasant Grove Utah
12. MAIDEN NAME OF MOTHER: Ivy Valentine
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salem Idaho.

14. Informant: Georgia Penfold
(Address): Driggs Idaho

15. Filed 7-11-, 1929. Martha Marker, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to July 1, 1929
that I last saw her alive on July 3, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Malneutrition caused from Nephritic condition of mother.
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. T. Parkinson, M. D.
7-1-, 1929 (Address) Driggs, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Darby, Ida. | Date of Burial: July 2nd 1929
20. Undertaker: — | Address: —

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67088

PLACE OF DEATH
County of Teton
City of Driggs

Registration District No. 77
Primary Registration District No. 9176

Local Registrar's No. 1

(No.) 167
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Floralynn Smith

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 8, 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Driggs
(State or country) Idaho

PARENTS

10. NAME OF FATHER Leonard Smith
11. BIRTHPLACE OF FATHER (city or town) Preston
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Willamelia Coleman
13. BIRTHPLACE OF MOTHER (city or town) St. Johns
(State or Country) Arizona

14. Informant Willamelia C. Smith
(Address) Driggs, Idaho

15. Filed 7-13-, 1929. Martha Markes.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24, 1929, to June 1, 1929
that I last saw her alive on May 31, 1929
and that death occurred, on the date stated above, at 5:50 a.m.

The CAUSE OF DEATH* was as follows:
Convulsions — Due to
Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Acute Bronchopneumonia
Influenza (duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) H. R. Reese, M. D.
June 7, 1929 (Address) Driggs, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Driggs, Idaho	June 3, 1929
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67089

PLACE OF DEATH
County of Teton
City of Victor

Registration District No. 77
Primary Registration District No. 2176
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

182

2. FULL NAME Nelda Berger.
(a) Residence. No. Victor Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) ~~WIFE of~~

6. DATE OF BIRTH (month, day and year) Oct 21 - 1926

7. AGE: Years 2 | Months 8 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Victor Ida

PARENTS

10. NAME OF FATHER: I R Berger
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Milloille Utah
12. MAIDEN NAME OF MOTHER: Violet E Fonks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Morgan Utah

14. Informant: E. M. Kearsley
(Address) Victor Idaho.

15. Filed 7-11-, 1929. Martha Marker, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.., to ....., 19..., that I last saw h.. alive on ....., 19..., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Accidental drowned

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Mrs. Martha Marker, Registrar, M. D.
7-3-, 1929 (Address) Driggs, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Victor Idaho | Date of Burial: 7-5- 1929

20. Undertaker: ..... | Address: .....

RECEIVED AUG 8 1929

PLACE OF DEATH

County of Twin Falls

City of Buhl

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 39

Primary Registration District No. 2087

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67091

Local Registrar's No. .....

164

2. FULL NAME Calvin Sowder

(a) Residence. No. Buhl Ida. St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE white

5. Single, Married, Widowed or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 23 1840

7. AGE Years 88 Months 8 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kent.

PARENTS

10. NAME OF FATHER John Sowder

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mrs - W H Priest

(Address) Buhl Idaho.

15. Filed 7-19, 1929 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st, 1929, to July 18, 1929

that I last saw him alive on July 16, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Senility Degenerations

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) R E Stuart, M. D.

July 18, 1929 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial~~, ~~Cremation~~, or Removal Madison Kans

Date of Burial 7/20 — 1929

20. Undertaker Merville D Rugg

Address Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXA should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact stateme TION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67092

PLACE OF DEATH
County of Twin Falls. Registration District No. 39
City of Buhl Primary Registration District No. 2087
(No. .....)
Local Registrar's No. .....

(If death occurred in a hospital or institution give its name instead instead of street and number.)

2. FULL NAME A. Clinton Smith

(a) Residence. No. Hansen R F D St. 90
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rhoda Smith

6 DATE OF BIRTH (month, day and year): July 4 1883

7 AGE: Years 46 Months 6 Days 12 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calif

PARENTS

10 NAME OF FATHER: Ezechial Smith
11 BIRTHPLACE OF FATHER (city or town) (State or country): Mo.
12 MAIDEN NAME OF MOTHER: Mary Brower
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calif.

14 Informant: Mrs. Rhoda Smith
(Address): Hansen R F D.

15 Filed 7-17-1929 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 16 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1929, to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 1:15 a.m.

The CAUSE OF DEATH* was as follows:
acute dilitation of heart

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Do not know.
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Supposed.

(Signed) J. H. Murphy, M. D.
July 17, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: July 19 1929
20. Undertaker: P. J. Grossman — Address: Twin Falls

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67093

PLACE OF DEATH
County of Twin Falls
City of Twin Falls Co Hospital

Registration District No. 39
Primary Registration District No. 2087
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Richard Cloyd King

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

167

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 11th-1929

7. AGE Years 0 Months 1 Days 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Castleford

PARENTS
10. NAME OF FATHER S. E. King
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennessee
12. MAIDEN NAME OF MOTHER Ruby Kendrick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tennessee

14. Informant S E King
(Address) Castleford

15. Filed 7-16, 1929 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929 to July 10, 1929
that I last saw him alive on July 10, 1929
and that death occurred, on the date stated above, at 7 a m.
The CAUSE OF DEATH* was as follows:
Pulmonary embolus following operation for Hypertrophic pylaric stenosis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pylaric stenosis
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of July 5-29
Was there an autopsy? no
What test confirmed diagnosis? Operation
(Signed) John H. Laughlin, M. D.
July 12, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Ida. Date of Burial July 11 1929

20. Undertaker L. J. Johnson Address Buhl Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

S OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67094

PLACE OF DEATH
County of Twin Falls
City of Kimberly

Registration District No. 37
Primary Registration District No. 2085

Local Registrar's No.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mathelene Dawald

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years: — Months: — Days: 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Kimberly Ida.

PARENTS

10. NAME OF FATHER Jacob Dawald
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Eva
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant Jacob Dawald
(Address) Kimberly Ida

15. Filed 8/10, 1929 H. N. Leite Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1929, to July 15, 1929 that I last saw her alive on July 15, 1929 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Throat

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ✓

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. E. Langenwalter M. D.
July 15, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: 7-16 1929

20. Undertaker: White Mortuary
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67095

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
(No.) Wilson
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Sophie Means Dunaway (Dedie) 74A
(a) Residence. No. Twin Falls, Ida, Route St. 3.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: James H. Dunaway

6. DATE OF BIRTH (month, day and year): June 12-1861

7. AGE: 68 Years, 1 Months, 2 Days. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Howard County Mo.

PARENTS
10. NAME OF FATHER: James M. Means
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Christian Co. Kentucky
12. MAIDEN NAME OF MOTHER: Sophie Tolson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo

14. Informant: Rose Dunaway Allen
(Address) R#3.

15. Filed 8/10, 1929 H. N. Leite Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to July 14, 1929
that I last saw her alive on July 14, 1929
and that death occurred, on the date stated above, at 7:00 a.m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage (apoplexy)
(duration) ... yrs. One mos. Hour ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H W Wilson M. D.
July 16, 1929 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Ida
Date of Burial: 7-16 1929

20. Undertaker: White Mortuary
Address: Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67096

PLACE OF DEATH
County of Twin Falls Registration District No. 37
City of [illegible] Primary Registration District No. 1085 Local Registrar's No.
(No. Co. Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Earl Kemp.

(a) Residence. No. Hansen RFD St. 710
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 24 1916

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
12	11	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer) (Rancher)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10 NAME OF FATHER Roy Kemp.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Neb.
12 MAIDEN NAME OF MOTHER Edna M Tilley
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa

14 Informant Roy Kemp.
(Address) Hansen R.F.D.

15 Filed 8/10, 1929 H N Leite Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 7 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 4th, 1929, to July 7th, 1929, that I last saw him alive on July 7th, 1929, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:
Cerebral Spinal Meningitis
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Rock Creek
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H E Reed, M. D.
July 8, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Twin Falls Date of Burial July 10 1929
20. Undertaker J J Gorman Address Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67097

PLACE OF DEATH

County of Twin Falls

City of " "

Registration District No. 37

Primary Registration District No. 1085

(No. 341 4th Ave No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

2. FULL NAME Lillian June Claycomb

(a) Residence. No. 341 4th no. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1612

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) July 5 1929

7 AGE Years Months Days 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ida.

PARENTS

10 NAME OF FATHER Cecil R. Claycomb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind.

12 MAIDEN NAME OF MOTHER Trilla Reams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah

14 Informant Cecil R Claycomb

(Address) 341 4th Ave No.

15 Filed 8/10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 8 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 5th, 1929, to July 8th, 1929, that I last saw her alive on July 7th, 1929, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows: Premature 7th mos.

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Lamb, M. D.

July 8th, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Twin Falls

Date of Burial July 8 1929

20. Undertaker J. J. Grossman Twin Falls

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 2085

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 67099

Local Registrar's No. .....

118B

2. FULL NAME Everett Allen Ghan

(a) Residence. No. Kimberly Ida Route #2
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. ~~Single, Married,~~ Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 2-1929

7. AGE: Years 1, Months 0, Days 6 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work X

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9. BIRTHPLACE (city or town) (State or country) Berger Idaho

PARENTS

10. NAME OF FATHER Clifford Allen Ghan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo

12. MAIDEN NAME OF MOTHER Dorothy Mills

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Clifford A. Ghan
(Address) Kimberly Ida

15. Filed 8/10, 1929 H N Leete Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 8 (Day) 1929 (Year)

17. I ~~HEREBY~~ CERTIFY, That I attended deceased from ~~July~~ 30, 1929, to July 7th 1929

that I last saw him alive on July 7th, 1929

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Obstruction of the bowel

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Infection of ears

(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of July 7th 29

Was there an autopsy? No

What test confirmed diagnosis? Operative

(Signed) H E Gant, M. D.

July 7th, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: 7-10 1929

20. Undertaker: White Mortuary — Address: Twin Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67100

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

43

2. FULL NAME Frank Dolana
(a) Residence. No. Buhl Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 22 1876

7. AGE Years 53 Months 4 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Czech Slovakia

PARENTS
10. NAME OF FATHER Frank Dolana
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Joe F. Dolana
(Address) Rupert.

15. Filed 8/10, 1929 H. N. Lutz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5th, 1929, to July 9, 1929
that I last saw him alive on July 9th, 1929
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Sarcoma of the thyroid
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Adenoma of thyroid (duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? yes Date of July 3 1929
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H. E. Lamb M. D.
July 10th 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Cemetery
Date of Burial 7/11 1929

20. Undertaker Merville D. Rugg
Address Buhl Ida.

RECEIVED AUG 17 1929

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6

PLACE OF DEATH
County of BOISE
City of ~~ADA.~~

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 61

(No. IDAHO CITY ROAD NEAR IDAHO CITY.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard Robert CLAPHAM

(a) Residence. No. IDAHO CITY, IDAHO. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	✓ Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) ✓ July 14 - 1888

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
✓ 41		24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work LABORAR
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ✓ Warren Township Lake Co, Illinois.

PARENTS

10. NAME OF FATHER ✓ Thomas Clapham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lincolnshire, England
12. MAIDEN NAME OF MOTHER Rachel Almond
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Thimbleby, England

14. Informant J W Clakcain
(Address) 708 Hickory St Waukegan Ill

15. Filed Aug 12 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH AUGUST 7th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19 to , 19~~ ~~that I last saw h alive on~~ Saw deceased dead August 7, 1929 and that death occurred, on the date stated above, at Boise Co. near Idaho City

The CAUSE OF DEATH* was as follows:
That the deceased met his death by gunshot wound from a rifle in his possession, accidentaly discharged, unless the bulbet, if found, proves otherwise, (Enquest Verdict)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. A. Schlosser Coroner. M. D.
Aug. 8th. 1929 (Address) BOISE. CO. IDAHO CITY IDA

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: WAUKEGAN, ILL. Date of Burial: 8/8/29
20. Undertaker: SCHREIBER & McCANN Address: BOISE, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Montgomery

RECEIVED AUG 12 1929

67103

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67103

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

Local Registrar's No. 66

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Abbie R Sappenfield

(a) Residence. No. 1416 Fillmore St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry C Sappenfield

6. DATE OF BIRTH (month, day and year) Jan 18 1864

7. AGE	Years	Months	Days	If LESS than 1 day,
	65	5	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marysville Calif

PARENTS

10. NAME OF FATHER Henry Clay Miner

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Janet Longwell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs R. Vance Wilkerson
(Address) 1416 Fillmore Caldwell Ida

15. Filed 7-12-, 1929 John S. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 10-29, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1927, to July 10, 1929
that I last saw her alive on July 10, 1929
and that death occurred, on the date stated above, at 4:30a m.

The CAUSE OF DEATH* was as follows:
Pernicious Anemia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Blood exams

(Signed) W. D. Montgomery M. D.
July 12, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	July 12-29
20. Undertaker	**Address**
Paul L. Case	Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 22 1929

67104

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67104

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2141
(No.) 205-a
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5623

2. FULL NAME Bernice Weber
(a) Residence. No. Blackfoot Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) June 16. 1896
7. AGE: Years 33 Months 1 Days 5 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER W. J. Fries
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pensylvania
12. MAIDEN NAME OF MOTHER Eula Dockslader
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y. State

14. Informant John F. Weber
(Address) Blackfoot
15. Filed July 22, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 21 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 7/16, 1929, to 7/21, 1929
that I last saw her alive on 7/21/29, 19
and that death occurred, on the date stated above, at 8a m.
The CAUSE OF DEATH* was as follows:
Following operation
Cause of death not known
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Appendectomy
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Don't know
Did an operation precede death? Yes Date of 7/17/29
Was there an autopsy? no
What test confirmed diagnosis? Usual signs
(Signed) J. C. Jaurie, M. D.
7/22, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Denver Colo. Date of Burial: July 22 1929
20. Undertaker: McHan Undt Co. Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

HAMNER C. IRWIN, M. D.
CARLSON BUILDING
SUITE 311-12-13-14
POCATELLO, IDAHO

Mrs J. L. Weber - seen by me 7/16/20
Heart & lungs. & urine neg. BP 110/68 - P82
Wt 137 -
Operation for chr. cystic ulcered cervix &
chr. app. 7/17/29
actual cautery to cervix - tube in cervix
Rt. rectus incision Guil abdo. exploration
upper. abdo neg - large hemorrhagic cyst
Rt. ovary resected - other organs normal
acutely inflamed retrocoecal, long appendix
Removed with ease -
Oozing from fundus of uterus where
uterus was elevated also from stump
of ovary - there fore a Pearsone drain
abdo closed in usual way
Patient stood oper. well & left table in
good condition
18th Condition good - voiding & expelling
flatus
19th Pulse rapid but of good quality
Pm. " " " " " temp
20 - Shallow breathing weak rapid pulse
no pain & not any pain at any
time - nausea - vomiting.
I don't know cause of death -
without an ascending infection
up to liver

7/22/29 H. C. Irwin.

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

6-7105

DO NOT WRITE IN THIS SPACE
State File No. 67105

Registration District No. 28
Primary Registration District No. 2101
Local Registrar's No. 5611

PLACE OF DEATH
County of ~~Bingham~~ Bannock
City of Pocatello
(No. R.R. Crossing North Of City)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME LaVern Walton

(a) Residence. No. No. Of Pocatello City St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

1892

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Lily Livingston

6. DATE OF BIRTH (month, day and year) Sept. 19, 1892.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	9	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) Tie Plant
(c) Name of employer O.S.L.R.R.

9. BIRTHPLACE (city or town) (State or country) Auburn, Wyoming.

PARENTS

10. NAME OF FATHER Joseph H. Walton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Mary Ann Wheelock
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant Mrs. Lily Walton
(Address) No. Of City

15. Filed 7/11, 1929. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw h.... alive on ....., 19....
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows:
Skull fracture hit by
R.R. train while riding in cab
(accidental)
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Arthur W Hall Coroner, M.D.
7/11, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	July 11, 19
20. Undertaker Arthur W. Hall	Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Dr. Parker

67107

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67107

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 220

(No. 2005 N. 17th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

107

2. FULL NAME Patrick Fitzgerald.

(a) Residence. No. 2005 N. 17th St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. *How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Nettie Fitzgerald.

6. DATE OF BIRTH (month, day and year): February 12th 1867

7. AGE: Years 62, Months 6, Days 12. If LESS than 1 day, ____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired from U.S. Army.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10. NAME OF FATHER: Micheal Fitzgerald.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Margaret Evans.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland.

14. Informant: Mrs. Patrick Fitzgeral.
(Address) Boise, Idaho.

15. Filed 8-26, 1929 W. H. Rhodes, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 24th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929, to Aug 24, 1929, that I last saw him alive on Aug 24, 1929, and that death occurred, on the date stated above, at 3:40 P.M.

The CAUSE OF DEATH* was as follows:

Abscess of right lung
strepto-coc. infection

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Strep. Infection of bladder & kidneys (duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) O H Parker, M. D.

8/26/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 8/27/29 19

20. Undertaker: Wm. McBratney. — Address: Boise, Idaho.

RECEIVED SEP 6 - 1929

67108

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67108

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 66

(No. Idaho Soldier's Home.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

177

2. FULL NAME Henry Harry Olsen

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) Jan. 27th 1898

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31	6	29	----------

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Civil Engineer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Oreana, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER
Harry Olsen.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)
Nykjoben, Denmark.

12. MAIDEN NAME OF MOTHER
Amelia Lychow

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Copenhagen, Denmark.

14. Informant Pearl Allen.

(Address) Boise, Idaho.

15. Filed 8-28, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August 26th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug 25, 1929, to Aug 25, 1929
that I last saw him alive on Aug 25, 1929
and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:
Accidental Chemical Poisoning from an overdose Veronal

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical findings

(Signed) Fred A. Fouraple, M. D.

8/28/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	8/29/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67109

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 224

PLACE OF DEATH

County of Ada
City of Boise
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME W. S. Roy Kibble

(a) Residence. No. 1915 - No 18th St.
(Usual place of abode)
Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Mabel M. Kibble

6. DATE OF BIRTH (month, day and year) July 20, 1884

7. AGE	Years	Months	Days	If LESS than 1 day,
	45	01	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Waco Nebr.

PARENTS

10. NAME OF FATHER William C Kibble
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Paris Illinois
12. MAIDEN NAME OF MOTHER Eliza E Graham
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Mrs. Marion Kibble
(Address) 1702 Franklin

15. Filed 8-30, 1929 W. A. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26, 1929, to Aug 28, 1929
that I last saw him alive on Aug 28, 1929
and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:
Mitral Stenosis & Chronic Myocarditis
(duration) 25 yrs. mos. ds.
CONTRIBUTORY (Secondary) Stasis & Pulmonary Circulation (duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. M. Bradshaw, M. D.
Aug 29, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	August 31 1929
20. Undertaker	Address
Summers & Krehs	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Quats

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6710

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 223

2. FULL NAME Emily Lyon

(a) Residence. No. 1510 - N. 24 st. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 4, 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	8	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marshall Missouri

PARENTS

10. NAME OF FATHER Camp. Gilmer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant George Lyon
(Address) 1510 N. 24th Boise

15. Filed 8-30, 1929 W. T. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/15, 1929, to 8/28, 1929
that I last saw h[illegible] alive on 8/27, 1929
and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Myocarditis
Toxic Goitre
Chronic Nephritis (interstitial)
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) A. Cook, M. D.
19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
West Yellowstone Mont.	8-31 1929
20. Undertaker	Address
Summers & Krebs	Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67111

County of Ada.
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 222
(No. 1211 Washington Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dr. Farrar William Skillern.

(a) Residence. No. 1211 Washington St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alice Skillern.

6. DATE OF BIRTH (month, day and year) July 19th 1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	1	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work M.D.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ray Co. Tenn.

PARENTS

10. NAME OF FATHER
William Skillern.

11. BIRTHPLACE OF FATHER (city or town) (State or Country)
Sequatchee, Tenn.

12. MAIDEN NAME OF MOTHER
Martha Farrar.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia.

14. Informant Ines Skillern Reller.
(Address) Twin Falls, Idaho.

15. Filed 8-27, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August 26th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 9th, 1929, to Aug 26th, 1929
that I last saw h[illegible] alive on Aug. 25th, 1929
and that death occurred, on the date stated above, at 6:00 a m.
The CAUSE OF DEATH* was as follows:
Intestinal toxemia causing respiratory disturbances
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility and chronic con-gestment (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? None

(Signed) J. M. Taylor, M. D.
8/26/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	8/28/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67112

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 221
(No. Oxford Hotel. Boise, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert Edward McNeil.

(a) Residence. No. Oxford Hotel. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. I mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

177

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eva McNeil.

6. DATE OF BIRTH (month, day and year) July 1st 1891

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	I	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Electrician.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Venice, Illinois.
(State or country)

PARENTS

10. NAME OF FATHER Don't Know.

11. BIRTHPLACE OF FATHER (city or town) " "
(State or Country)

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) " "
(State or Country)

14. Informant Mrs. A. E. McNeil.
(Address) Boise, Idaho.

15. Filed 8-26, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 23rd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/22, 1929, to 8/23, 1929
that I last saw him alive on 8/23, 1929
and that death occurred, on the date stated above, at 4:50 PM.

The CAUSE OF DEATH* was as follows:

accidental
Ingestion of Tincture of
Iodine & alcoholic bout
(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Pulmonary embolism 3 min
(duration) yrs. mos.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History

(Signed) C. S. Allen, M. D.
8/26/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Venice, Illinois. Date of Burial Shipped 8/26/29 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67113

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1064
Local Registrar's No. 219

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME A M Shay

(a) Residence. No. 1401 North 7th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Flora Shay

6. DATE OF BIRTH (month, day and year) Sept 10, 1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	11	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lebanon Pennsylvania

PARENTS

10. NAME OF FATHER Geo Shay
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cornwall Pennsylvania
12. MAIDEN NAME OF MOTHER Anna Baldwin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Cornwall Pennsylvania

14. Informant Mrs. Flora Shay
(Address) Meridian, Ida

15. Filed 8-26, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 24th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28th, 1929, to Aug 24th, 1929
that I last saw h[illegible] alive on Aug 24th, 1929
and that death occurred, on the date stated above, at 2:50 P.M.
The CAUSE OF DEATH* was as follows:
Angina pectoris
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hodgkins disease
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A B Bonk, M D.
Aug 26th 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation,~~ or Removal	Date of Burial
Boise, Morris Hill	Aug 27 1929

20. Undertaker E W Robison
Address Meridian Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 3 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67114

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 218
(No. 10)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mettie Campbell Graham

(a) Residence. No. 1206 E. Jefferson St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert E. Graham

6. DATE OF BIRTH (month, day and year) Sept. 25 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	10	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Enoch Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Sally Sharp
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Robert E. Graham
(Address) 1206 E. Jefferson St. Boise Idaho

15. Filed 8-23, 1929 W. W. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1929, to Aug 22, 1929,
that I last saw her alive on Aug 22, 1929,
and that death occurred, on the date stated above, at 1:30 p m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage with paralysis of right side.
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Auricular Fibrillation
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. A. Forbush, M. D.
Aug 23, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Aug 24 '29
20. Undertaker	Address
Simmons & Reba	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67115

PLACE OF DEATH

County of Ada

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 217

(No. 2316 Lemp Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

J 49

2. FULL NAME Mrs. Martha Jane Hart.

(a) Residence. No. 2316 Lemp St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Willard O. Hart.

6. DATE OF BIRTH (month, day and year): February 2nd 1844

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
85	6	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Trumansburg, N. Y.

PARENTS

10. NAME OF FATHER: John Lucas.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland.

12. MAIDEN NAME OF MOTHER: Irene Hazzard.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pa.

14. Informant: Robert J. Hart.

(Address): San Francisco, Cal.

15. Filed 8-23, 19 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 22nd 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1929, to Aug. 22, 1929 that I last saw her alive on Aug. 22, 1929 and that death occurred, on the date stated above, at 5:50 A.M. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Bladder

(duration) 1½ yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Cardio-vascular diseases.

(duration) 25 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam & Findings

(Signed) Dr. J. H. Davis, M. D.

8/22/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 8/24/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67116

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hos.) 162
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 216

2. FULL NAME Baby Brassey
(a) Residence. No. ..... St. Parents Placerville, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 21-1929

7. AGE Years | Months | Days | If LESS than 1 day, 9 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Ida

PARENTS
10. NAME OF FATHER W. C. Brassey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Mary J. Fairchild
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ida

14. Informant W. C. Brassey
(Address) Placerville Ida.

15. Filed 8-21, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/21, 1929, to 8/21, 1929
that I last saw him alive on 8/21, 1929
and that death occurred, on the date stated above, at 9:30 A m.
The CAUSE OF DEATH* was as follows:
Inertia - Baby weighs 4 lbs. at birth died 6 hrs later
normal birth (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Know of no other reason for death. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Fred A. Pittenger M. D.
8/21, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Placerville — Date of Burial: 8/22 1929

20. Undertaker: Schreiber & McCann — Address: Boise 2

Dr Pittenger

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67117

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 215

2. FULL NAME Melvin Laforest Carlton

(a) Residence. No. St Lukes Hospital St.
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Agnes Carlton

6. DATE OF BIRTH (month, day and year): July 15, 1856

7. AGE: Years 73 | Months 0 | Days 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Stockman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: James Carlton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Rebecca Waeker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tennessee

14. Informant: Mrs. Christie R. DeMyer
(Address) 723 Ada St Boise Idaho

15. Filed 8-15, 1929 W. F. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 13 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1919, to Aug 13, 1929, that I last saw him alive on Aug 6, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
1 Arteriosclerosis Deformans
2 Myocardial Insufficiency
3 Chronic Myocarditis
(duration) 20 yrs. mos. d.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. d.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) James Clayton, M.
Aug 15, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hillcrest Cemetery — Date of Burial: Aug 15, 1929
20. Undertaker: Simmons & Kirtz — Address: Boise Idaho

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 87118

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 214

PLACE OF DEATH
County of Ada
City of Boise
(No.) St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Michel Odiaga
(a) Residence. No. 116 South 6th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 29-1915

7. AGE	Years	Months	Days	If LESS than 1 day,
	13	10	26	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Student
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Ida

PARENTS
10. NAME OF FATHER Jose Odiaga
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spain
12. MAIDEN NAME OF MOTHER Yunita Mendagora
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spain

14. Informant
(Address) Mrs John Arbea

15. Filed 8-15-1929 W. D. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1929, to aug 13, 1929
that I last saw him alive on aug 9, 1929
and that death occurred, on the date stated above, at 6:50 m.
The CAUSE OF DEATH* was as follows:
Spotted Fever
+ Colitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Nephritis
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? Jumper Mt. Owyhee Co.
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Spots + eruption
(Signed) W. H. Wahl M. D.
aug 15, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Johns Cemetery	8/16 1929

20. Undertaker	Address
Schneider & McCann	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Ada

DO NOT WRITE IN THIS SPACE

State File No. 67119

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1904

Local Registrar's No. 213

(No. St Lukes Hospital) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Minnerly

(a) Residence. No. 1925 N. 18 St. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 14-1929.

7. AGE	Years	Months	Days	If LESS than 1 day,
			1	4 Hours hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho.

PARENTS

10. NAME OF FATHER Clarence E Minnerly

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Thelma Jennings

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Calif.

14. Informant Clarence E Minnerly

(Address) 1925 N. 18 St Boise Idaho

15. Filed 8-15, 1929 W. W. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 15, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1929, to Aug 15, 1929

that I last saw h.. alive on Aug 14, 1929

and that death occurred, on the date stated above, at 3:15 A m.

The CAUSE OF DEATH* was as follows:

Premature - conditions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Coats by Herald T. Hok M. D.

Aug 15, 1929 (Address) 402 Eastman Bldg Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Aug 15 1929
20. Undertaker	Address
Summers & Kirk	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 6 - 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No St. Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67120

Local Registrar's No. 211

2. FULL NAME William Robinson

(a) Residence. No. Star Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. 6 mos. da ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ida Robinson

6. DATE OF BIRTH (month, day and year) Nov. 4, 1855

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	9	7	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Melancton Robinson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Rebbecka Wallace

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York.

14. Informant Laverne Robinson

(Address) Emick Idaho.

15. Filed 8-12, 1929 W. D. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1929, to Aug 11, 1929

that I last saw him alive on Aug 11, 1929

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma head of pancreas

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 5 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) L. T. West, M. D.

8-12, 1929 (Address) 413 Eastman Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fruitland Cemetery	Aug 13 1929
20. Undertaker	Address
Summers & Kuelz	Boise Ida

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67122

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 210
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chester C. Bruno.

(a) Residence. No. Meridian, Route #3 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nora O. Bruno

6. DATE OF BIRTH (month, day and year) April 5th 1898

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31	4	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Robert Bruno.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Fannie Draper

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant Mrs. O. C. Bruno.
(Address) Meridian, Idaho.

15. Filed 9-12, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 10th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ ~~, to~~ ~~, 19~~ ~~that I last saw him alive on~~ about ~~, 19~~ and that death occurred, on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:
Auto accident. Following is Jury verdict. (By means of criminal carelessness on the part of Berney Stewart.) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Inquest held 8/12/29
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? None
(Signed) James McBratney, Coroner, M. D.
8/12/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kuna Cemetery. Date of Burial: 8/13/29 19

20. Undertaker: B. W. Robison. Address: Meridian, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 8 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67123

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 209
pw.

2. FULL NAME Humphrey Frank Carey
(a) Residence. No. 611 Grove St. 100a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Don't know

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Abou 70

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Modern Barber Shop

9. BIRTHPLACE (city or town) (State or country) Mass.

PARENTS
10. NAME OF FATHER Not attainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. ~~Informant~~ Filed 8-12-29 W. H. Rhodes
(Address) Registrar
~~Filed~~ Informant 9, 19 Parker ~~Registrar~~
Boise Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 5, 1929, to Aug. 8, 1929
that I last saw him alive on Aug 7, 1929
and that death occurred, on the date stated above, at 12 30 A. m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Chronic Nephritis - Senility
Incarcerated ventral hernia and Intestinal obstruction (duration) ? yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yrs Date of Aug. 6, 1929
Was there an autopsy? yrs
What test confirmed diagnosis? autopsy findings
(Signed) H. E. Dedman, M. D.
Aug. 10, 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Johns Cemetery — Date of Burial: 8/13 1929

20. Undertaker: Schreiber & McCann — Address: Boise

RECEIVED FEB 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67123

Dr. H.E. Dedman
Boise

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

Special Agent, Bureau of Census.

In reference to the death certificate of:

Humphrey Frank Crey who died Aug. 8, 1929
Cause of death given as "Broncho Pneumonia." "Chronic nephritis--Senility."

Information DESIRED in order to complete certificate.

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW

~~Stat~~ Incarcerated Ventral hernia with Intestinal Obstruction.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 6 - 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. St. Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 87124

Local Registrar's No. 288

2. FULL NAME Mildred Ross

(a) Residence. No. Mountain Home Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Single.

6. DATE OF BIRTH (month, day and year): 10-7-1916

7. AGE — Years: 12 | Months: 10 | Days: 2 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: X

9. BIRTHPLACE (city or town) (State or country): Billings, Montana.

PARENTS

10. NAME OF FATHER: Roy F. Ross,

11. BIRTHPLACE OF FATHER (city or town) (State or Country): ✓ Mountainhome, Idaho

12. MAIDEN NAME OF MOTHER: Mildred L. Britton,

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Marsland, Nebr.

14. Informant: Mrs. Mildred L. Ross,

(Address) Mt. Home, Idaho, Box 75.

15. Filed 8-10, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 9, (Month) (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1925, to Aug. 9, 1929,

that I last saw h-er alive on Aug 9, 1929

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH was as follows:

Diabetic Coma

(Diabetes Mellitus)

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilitation of Stomach (duration) 2 yrs. mos. 2 ds.

Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory + Autopsy

(Signed) Ernest E. Lamborn M. D.

8-10-29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain Home Idg — Date of Burial: Aug 10 1929

20. Undertaker: Summers & Rhodes — Address: Boise Idg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67125

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No.)
Local Registrar's No. 207

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Henry Hawley

(a) Residence. No. 719 Main St
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Mary Elizabeth Hawley

6. DATE OF BIRTH (month, day and year) Jan 18 - 1847

7. AGE: Years 82 | Months 6 | Days 16 | If LESS than 1 day, ...hrs. or ...min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country) Dubuque Iowa

PARENTS

10. NAME OF FATHER Thomas Hawley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) United States
12. MAIDEN NAME OF MOTHER Anna Carr Hawley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) United States

14. Informant Jesse B. Hawley
(Address) Boise, Ida

15. Filed 8-9, 1929 W. A. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15, 1929, to 8/3, 1929
that I last saw him alive on 7/5, 1929
and that death occurred, on the date stated above, at 2:25 P m.
The CAUSE OF DEATH* was as follows:

Degeneration Myocardetis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Senility

(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Findings
(Signed) Fred A. Pettyjohn, M. D.
8/5, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Johns Cemetery
Date of Burial: 8/6 1929

20. Undertaker: Schreiber & McCann
Address: Boise

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67126

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 204

2. FULL NAME Mary Ethel Christensen
(a) Residence. No. 510 No 2nd St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

145-a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Fred S Christensen

6. DATE OF BIRTH (month, day and year) Sept 18 - 1893

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
35	10	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): So. Dak.

PARENTS

10. NAME OF FATHER — Hyland
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada ~~No Record~~
12. MAIDEN NAME OF MOTHER: Margaret Morrison
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): No Record

14. Informant: Fred S Christensen
(Address) Boise Ida

15. Filed 8-7, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to Aug. 4, 1929
that I last saw her alive on Aug 4, 1929
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows: Pneumonia and intestinal obstruction following caesarian section
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of July 29 - 1929
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P. P. French, M. D.
Aug. 5, 1929 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetry
Date of Burial: 8-6 1929

20. Undertaker: Schreiber McCann
Address: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMA[illegible]
N. B.—Every item of information should be carefully supplied. AGE should be [illegible] [illegible]SICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classifi[illegible] [illegible]nt of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67127

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 205

159e

2. FULL NAME Baby Christeauson
(a) Residence. No. 510 No 2nd St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) July 29 - 1929

7. AGE — Years — Months — Days 7 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise Ida

PARENTS
10. NAME OF FATHER: Fred. S. Christeausen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Minden Neb.
12. MAIDEN NAME OF MOTHER: Mary Ethel Hyland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): So. Dak.

14. Informant: Fred S. Christensen
(Address) Boise Ida

15. Filed 8-7, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to Aug 4, 1929
that I last saw her alive on Aug 4, 1929
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows: Starvation
Baby was abnormal at birth
Unable to retain nourishment
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P P French, M. D.
Aug 5, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Schreiber McCann
Date of Burial: 8-6 1929

20. Undertaker: Morris Hill Cemetry
Address: Boise

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67128

County of ADA
City of BOISE
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 206
(No. 32)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME MARY PILAR ECHEVARRIA

(a) Residence. No. 214 EAST BANNOCK STREET St.
(Usual place of abode)
Length of residence in city or town where death occurred. 20 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) SEPTEMBER 13th. 1908

7. AGE	Years	Months	Days	If LESS than 1 day,
	20	10	25	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work CLERK

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer THE MODE.

9. BIRTHPLACE (city or town) (State or country) BOISE, IDA.

PARENTS

10. NAME OF FATHER VICTOR ECHEVARRIA

11. BIRTHPLACE OF FATHER (city or town) (State or Country) SPAIN

12. MAIDEN NAME OF MOTHER VICTONIO ABADTHEA

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) SPAIN.

14. Informant Juan Echevarria
(Address) Boise

15. Filed 8 9, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
June, 1929, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Meningeal tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Tom Collins, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
ST. JOHN'S CEMETERY	8/10/29 19

20. Undertaker Schreiber & McCann Address Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67129

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 201
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

117

2. FULL NAME Audrey Lucile Hicks.

(a) Residence. No. Boise, Idaho R. #3 St.
(Usual place of abode)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) March 17th 1926

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3	4	16	----------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Ray Hicks.
11. BIRTHPLACE OF FATHER (city or town) LaCross, Wisconsin.
(State or Country)
12. MAIDEN NAME OF MOTHER Mabel Glenn.
13. BIRTHPLACE OF MOTHER (city or town) Boise, Idaho.
(State or Country)

14. Informant Ray Hicks.
(Address) Boise, Idaho.

15. Filed 8-6, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 3rd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to Aug 3, 1929
that I last saw h[illegible] alive on aug 3, 1929
and that death occurred, on the date stated above, at 9 P.M. m.
The CAUSE OF DEATH was as follows:
acute appendicitis (Ruptured
(duration) yrs. mos. 16 ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? Yes Date of aug 3. 1929
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) P P French, M. D.
8/5/29, 19 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	8/5/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67130

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 202

(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Miss Nannie Gribble.

(a) Residence. No. 139 Emmett, Idaho. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) March 16th 1885

7. AGE Years	Months	Days	If LESS than 1 day, ---------- hrs. or ---------- min.
44	4	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pittsburg, Kans.

PARENTS

10. NAME OF FATHER George Gribble.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wis.

12. MAIDEN NAME OF MOTHER Margaret Manuel.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wis.

14. Informant Mrs. George Gribble.
(Address) Emmett, Idaho.

15. Filed 9-6, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 4th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25, 1929, to August 4, 1929
that I last saw h[illegible] alive on August 4, 1929
and that death occurred, on the date stated above, at 10.30 a. m.
The CAUSE OF DEATH* was as follows:
Fibroid Tumor of Uterus
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Diabetes
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of July 29, 29
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Harold W. Stone M. D.
8/5/29, 19 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian, Idaho.	19

20. Undertaker	Address
Wm. McBratney	Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67131

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No.) St. Alphonsus
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 203

2. FULL NAME Mary A. Rogers
(a) Residence. No. 99 B St. Meridian Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Geo Rogers. (deceased)

6. DATE OF BIRTH (month, day and year) Nov. 20, 1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	8	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dayton Ohio

PARENTS

10. NAME OF FATHER Geo. W. Metcalf
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Phoebe A. Conklin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Edna M. Rogers
(Address) Boise Ida

15. Filed 8-7, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 6th (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18, 1929, to Aug. 6, 1929
that I last saw h[illegible] alive on Aug 6, 1929
and that death occurred, on the date stated above, at 9:30 A.m.
The CAUSE OF DEATH* was as follows:
Myocarditis & Cardiac Failure
(duration) ? yrs. ? mos. ds.
CONTRIBUTORY (Secondary) Phlebitis - left leg following Cholecystostomy (duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 6/18/29
Was there an autopsy? no
What test confirmed diagnosis? Physical findings -
(Signed) Ralph Falk, M. D.
Aug. 7, 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Ida	Aug 8 1929
20. Undertaker B W Robison,	Address Meridian Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67132

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 197
(No.) St Lukes Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sadie Parker

(a) Residence. No. 1216 Colorado St.
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 1-1859

7. AGE: Years 70 | Months 7 | Days 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10. NAME OF FATHER: Webster Paxson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Beulah Stewart
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: Mrs Leslie Rose
(Address) 1216 Colorado St Boise Ida

15. Filed 8-2, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to Aug 1, 1929
that I last saw her alive on July 31, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Strangulated Hernia
~~Fracture~~ (Left femoral)
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Shock
(duration) yrs. mos. 7 hr

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? Yes Date of July 31 1929
Was there an autopsy? No
What test confirmed diagnosis? Operation

(Signed) T. N. Boynton, M. D.
Aug 2, 1929 (Address) Boise
Operation by Dr H. W. Stone

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal: Morris Hillcrest Cemetery — Date of Burial: Aug 2 1929
20. Undertaker: Summers & Turpin — Address: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67133

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 198

1004

2. FULL NAME Levi T. Kelley
(a) Residence. No. ..... St. Filer, Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~Single, Married, Widowed, or Divorced (write the word)~~

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6. DATE OF BIRTH (month, day and year): March 10, 1849

7. AGE: Years 80, Months 4, Days 23, If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer (retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Dont Know West Va.

PARENTS
10. NAME OF FATHER: Kelley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dont Know

14. Informant: Otis Kelley
(Address): Filer Ida

15. Filed 8-2, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2nd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1929, to Aug. 2, 1929
that I last saw him alive on Aug. 1, 1929
and that death occurred, on the date stated above, at 2:20 A.m.
The CAUSE OF DEATH* was as follows:
Terminal Broncho-pneumonia
..... (duration) ..... yrs. ..... mos. 2-3 ds.
CONTRIBUTORY (Secondary): Hypertrophied Prostate + operation for removal
..... (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? yes Date of 7/27/29
Was there an autopsy? no.
What test confirmed diagnosis? Physical Exam.
(Signed) H. E. Ardman, M. D.
Aug 2, 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer Ida
Date of Burial: 19

20. Undertaker: B. W. Robison
Address: Meridian Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67134

PLACE OF DEATH

County of Ada.

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 199

(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Wacker

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 1861

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8. OCCUPATION OF DECEASED Laborer

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Dr. Rosenbaum
(Address) Boise Ida

15. Filed 8-3, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 30th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15th, 1928, to July 30th, 1929
that I last saw h[illegible] alive on July 30, 1929
and that death occurred, on the date stated above, at 10 P.M. m.
The CAUSE OF DEATH* was as follows: Uraemia - accompanied by Coma - due to Chronic Interstitial nephritis -
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis Bourk, M. D.
8/2/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	8-3-29 19
20. Undertaker: Wm. McBratney	Address: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67135

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 200

2. FULL NAME John Henry Van Hyning
(a) Residence. No. 1708 Ninth 20 St.
(Usual place of abode)
Length of residence in city or town where death occurred. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

91a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie Van Hyning

6. DATE OF BIRTH (month, day and year): Jan 25 - 1862

7. AGE: Years 67, Months 6, Days 5. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Milo, Iowa

PARENTS
10. NAME OF FATHER: William Henry Van Hyning
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Lydia Gardner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mich

14. Informant: W V Van Hyning
(Address) Des Moines Iowa

15. Filed 8-5, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to July 30, 1929
that I last saw him alive on July 28, 1929
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Aneurysm of Aortic Arch
(duration) 1 yrs. 2 mos. 14 ds.
CONTRIBUTORY (Secondary): Pulmonary Hemorrhage (duration) yrs. mos. 1 hr

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) T. N. Brashan M. D.
July 31, 1929 (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Aug 4 1929

20. Undertaker: Schreiber & McCann
Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67136

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 196

PLACE OF DEATH

County of ADA
City of BOISE
(No. ST. ALFONSUS? HOSP!T.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME REV. ARTHUR MOULTON.

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) FEBR. 2.1886.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	5	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work CATHOLIC PRIEST.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) WASHINGTON, D.C.

PARENTS

10. NAME OF FATHER UNKNOWN

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant REV. I.M.SULIVAN.
(Address) NAMPA, IDA.

15. Filed 8-2, 1929 W.N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JULY (Month) 31 (Day) 1929. (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 19 9, to July 31, 19 9
that I last saw h. alive on July 30, 19 9
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? T.B.

(Signed) Chas V Timmons, M. D.
Aug 2, 19 9 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
CATHOLIC CEM. NAMPA.	8.3.1929
20. Undertaker	Address
FRED K. ROBINSON	NAMPA?IDA.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67137

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 68

(No. U. S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Christian Meyers

(a) Residence. No. Jersey City, N. J. St. 31
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. x yrs. 8 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6. DATE OF BIRTH (month, day and year) 6-2-1897

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	2	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: General Salesman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: xx

9. BIRTHPLACE (city or town) (State or country): N.J.

PARENTS

10. NAME OF FATHER: xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country): xx

12. MAIDEN NAME OF MOTHER: xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): xx

14. Informant M. Cornelius
(Address) U. S. Vet. Bureau, Boise, Idaho

15. Filed 8-31, 1929 W. T. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-9-28, 19..., to 8-30-29, 19...
that I last saw h... im alive on August 30, 19 29
and that death occurred, on the date stated above, at 11 P.M. m.
The CAUSE OF DEATH* was as follows:

Tbc.pul.chr.act with multiple cavitation, far advanced "C"

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) none
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? xx
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy & Laboratory

(Signed) F.C.Smith, Reg.Med.Offr., M. D.
19... (Address) U.S.V.B.Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jersey City, N. J. Date of Burial: Shipped 9/1/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6738

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 67

PLACE OF DEATH
County of Ada
or Town Boise
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maselino Arana
(a) ~~Residence.~~ No. 8 Miles North West of Boise
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Maria Arana
6. DATE OF BIRTH (month, day and year): June 2-1877
7. AGE — Years: 52 | Months: 2 | Days: 25 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Spain

PARENTS
10. NAME OF FATHER: Marcos Arana
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Spain
12. MAIDEN NAME OF MOTHER: Maria Malen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Spain

14. Informant: Marie Arana
(Address): Boise, Idaho
15. Filed 8-30, 1929 W. D. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 27 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from August 22, 1929, to August 27 1929
that I last saw h was alive on August 27, 1929
and that death occurred, on the date stated above, at 8:45 P m.
The CAUSE OF DEATH* was as follows: Perforation of Duodenal Ulcer
Chronic for (duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Perforation occured at 1:00 P.M. 8/27/29 (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) T. H. T Linston, M. D.
8/28, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Johns Cemetery — Date of Burial 19
20. Undertaker: Schneider & Williams — Address: Boise

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67139

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 65
(No. 164)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Galena Caroline Brown

(a) Residence. No. 3 Miles West of Boise
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 21 1856

7. AGE: Years 73 | Months 5 | Days 3 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: Joseph Sexton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tennessee
12. MAIDEN NAME OF MOTHER: Elizabeth Pope
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Mrs. E. A. Eytchison
(Address) Marsing Idaho

15. Filed 8-28, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 19, 1929, to Aug 23 1929
that I last saw her alive on Aug 23, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Geo Calvert M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dry Creek Cemetery	Aug 26 1929
20. Undertaker	Address
Summers & Kirk	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67140

PLACE OF DEATH

County of Ada

near Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 64

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

128

2. FULL NAME Wong Fong

(a) Residence. No. Davis Ranch 1 mile West of City
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Yellow

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Wong

6. DATE OF BIRTH (month, day and year): 1852

7. AGE: About 77 Years; Months —; Days —; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Gardner

(b) General nature of industry, business, or establishment in which employed (or employer): Raising Vegetables

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): China

PARENTS

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (city or town) (State or Country): China

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): China

14. Informant: Wong
(Address) Boise

15. Filed 8-26, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1929, to Aug 23, 1929

that I last saw him alive on Aug 23, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Acute Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Gro collect

(Signed) ....., M. D.

....., 19..... (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Chinese Plot Ada County — Date of Burial: 8/26 1929

20. Undertaker: Schreiber & McCann — Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No. U. S. Vet. Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67141

Local Registrar's No. 63

74a 8

2. FULL NAME Albert ENDSLEY

(a) Residence. No. Boise, Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. X yrs. X mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Wd

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 6-11-1847

7. AGE	Years	Months	Days	If LESS than 1 day,
	82	2	12	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant M. Cornelius

(Address) U. S. Vet. Bureau, Boise, Idaho

15. Filed 8-23, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 23, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 13, 19 29, to August 23, 19 29
that I last saw h im alive on August 23, 1929, 19
and that death occurred, on the date stated above, at 4:55 A.M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage with residuals

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. C. Smith, Reg.Med.Officer, M. D.

, 19 (Address) U.S.Vet.Bureau
Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	8-25-29 19
20. Undertaker	Address
Wm. McRatney	Boise, Idaho

RECEIVED SEP 26 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Sept. 24, 1929

F.C. Smith 67141

Boise, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

G. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

Albert Endsley who died Aug. 23, 1929 at Boise, Idaho

Information DESIRED in order to complete certificate.

Was he single, married, widowed, or divorced?

PLEASE ANSWER BELOW 9-25-29

This patient was brought into the hospital in a semi-conscious condition. While he apparently understood what was said to him, he did not talk. He was advanced in years, and suffering from a marked hemiplegia. It was impossible to get the above information from him.

F.C. Smith

F.C.SMITH
Regional Medical Officer.
Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67142

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 62
(No. U. S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

57 8

2. FULL NAME Orvil BRADSHAW

(a) Residence. No. Boise, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. X yrs. X mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 12, 1895

7. AGE	Years	Months	Days	If LESS than 1 day,
	34	3	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ark.

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) W

12. MAIDEN NAME OF MOTHER W

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) W

14. Informant M. Cornelius
(Address) U. S. Vet. Bureau, Boise, Idaho.

15. Filed 8-19, 1929 W. Z. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1929, to Aug. 16, 1929
that I last saw him alive on August 16, 1929
and that death occurred, on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? XX
Did an operation precede death? no Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Laboratory & autopsy

(Signed) F.C. Smith, Regional Medical Officer, M. D.
(Address) U.S.V.B. Boise, Idah
, 19

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pratt, Kansas	19

20. Undertaker	Address
Wm. McBratney	Boise, Ida.

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67143

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 60

(No. Ada. County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ole G. Olson

(a) Residence. No. Silver City, Idaho. St. 1010

(If nonresident give city or town and State)

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) W

12. MAIDEN NAME OF MOTHER W

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) W

14. Informant Pearl Allen.

(Address) Boise, Idaho.

15. Filed 8-6-, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 3rd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1928, to Aug 3, 1929
that I last saw her alive on Aug 2, 1929
and that death occurred, on the date stated above, at 9 AM m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia of right lower Lobe

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis & Chronic Myocarditis

(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ada County
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J. M. Bradshaw, M. D.
8/5/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	8/6/29
20. Undertaker W. McBratney	Address Boise Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67144

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 59

(No. Boise River near Fairview Bridge.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME Jess Wilson.

(a) Residence. No. 2315 Regan St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) February 14th 1867

7. AGE: Years 62; Months 5; Days 15; If LESS than 1 day, ---------- hrs. or ---------- min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Steam Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Penn.

PARENTS

10. NAME OF FATHER: Unknown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Paul Shoemaker.
(Address) Boise, Idaho.

15. Filed 8-2, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July [redacted] 30th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ---------- 19---, to ---------- 19---
~~that I last saw him alive on~~ ---------- 19---
~~and that~~ death occurred, on the date stated above, at ---- m.

The CAUSE OF DEATH* was as follows: Found Dead on Bank of Boise River; Cause Unknown but natural from all that can be learned.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): No foul play.
(duration) yrs. mos. ds.

No. Inquest held.

18. Where was disease contracted if not at place of death? ----

Did an operation precede death? No. Date of ----

Was there an autopsy? No.

What test confirmed diagnosis? ----

(Signed) W. McBratney, Coroner, ~~M. D.~~

8/2/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 8/2/29 19

20. Undertaker: Wm. McBratney.
Address: Boise, Ida.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED AUG 21 1929

1. [redacted] OF DEATH

CERTIFICATE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 67145

Registered No. .....

County of Adams

City of Indian Valley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oren Leonidas Byers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Maried

6. DATE OF BIRTH. March (Month) 31 (Day) 1860 (Year)

7. AGE: 69 Yrs. ## Mos. 24 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Amos S Buers

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Rucke C Barner

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marquetta Byers

(Address) Indian Valley Ida

15. Filed 8-20-29 191.... Local Registrar

MEDICAL CERTIFICATE OF DEATH

74a

16. DATE OF DEATH April (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24 1929, to April 24 1929, that I last saw him alive on April 24 1929, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G. F. Hunt M.D.

19.... (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Valley — DATE OF BURIAL: Aug 25 1929

20. UNDERTAKER: J A Tuddleson — ADDRESS: Council

SYMS - YORK CO., PTRS. & BDRS. 24854

RECEIVED AUG 22 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67146

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5636

(No. Doc. General Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Jackson

(a) Residence. No. 816. W. Wyeth St. 88 B
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 20 1861

7. AGE: 68 Years, 6 Months, 29 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nebraska

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Mrs. Vance Barnett
(Address) Pocatello Ida

15. Filed Aug 20, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-18, 1929, to 8-18, 1929

that I last saw her alive on 8-18, 1929

and that death occurred, on the date stated above, at 3, P. m.

The CAUSE OF DEATH* was as follows: Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Young M. D.

8-18, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Idaho — Date of Burial: Aug 20 1929

20. Undertaker: McHan Undt Co — Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67147

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5635

118 B

2. FULL NAME Nicholas Blatt
(a) Residence. No. 121 Randolph St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 24-1878

7. AGE Years 51 Months 4 Days 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Plastering
(b) General nature of industry, business, or establishment in which employed (or employer) Contractor
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Blatt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Vincent Blatt
(Address) 121 Randolph Ave

15. Filed 8/12, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Aug 6, 1929
that I last saw him alive on Aug 6, 1929
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows: Thrombosis mesenteric veins. Causing acute intestinal obstruction - Injury in auto accident near Pocatello about 20 days ago (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Probable injury about 20 days previously. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Aug 6-29
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) A. M. Newton, M. D.
Aug 9, 1929 (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View
Date of Burial Aug 12 1929

20. Undertaker Schumacher & Beasley
Address City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67147

Dr. A.M. Newton
Pocatello, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Nicholas Blatt who died Aug. 6, 1929.
Contributory cause of death given as "Probable injury about 20 days previously."

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AN AUTO WAS INVOLVED PLEASE NAME THE PLACE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Mr Blatt was injured about twenty days before his death in an automobile accident near Pocatello.

A.M. Newton M.D.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 22 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of McCammon

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2141

(No. ....., ... St.)

File No. 67148

Registered No. 5634

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME No name

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 23 (Day) 1929 (Year)

7. AGE: — Yrs. — Mos. — ds.

IF LESS than 1 day how many — hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: ~

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): McCammon, Ida

10. NAME OF FATHER: C. W. Ketchum

11. BIRTHPLACE OF FATHER (State or Country): Pensylvania

12. MAIDEN NAME OF MOTHER: Charlott Harris

13. BIRTHPLACE OF MOTHER (State or Country): McCammon Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. H. Ketchum

(Address) McCammon, Ida

15. Filed 8 12 1929

J. R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

206

16. DATE OF DEATH: July (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 19..., to ~ 19...,

that I last saw h— alive on ~ 19...,

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Still Birth

Cause Unknown

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Hartigsen M. D.

7-23 1929 (Address) Downey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCammon Ida

DATE OF BURIAL: 7-23-1929

20. UNDERTAKER: C H Ketchum

ADDRESS: McCammon

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

174566 +

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67149

Registration District No. 28
Primary Registration District No. 24-1
Local Registrar's No. 5633

PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 133)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clara Burdow Fargo

(a) Residence. No. Fargo Apartments St.
(Usual place of abode)
Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 12 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	1	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Manager - apartments
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Fargo Bros.

9. BIRTHPLACE (city or town) (State or country) Stafford N. Y.

PARENTS

10. NAME OF FATHER Robert S. Fargo
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Stafford, N. Y.
12. MAIDEN NAME OF MOTHER ~~Rosalyn~~ Caroline Burdow
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Santan Court - Devonshire England

14. Informant C. G. Wells
(Address) 710 - N. Garfield

15. Filed 8/12, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/1, 1929, to 8/8, 1929
that I last saw her alive on 8/7, 1929
and that death occurred, on the date stated above, at 5:30 a.m.
The CAUSE OF DEATH* was as follows:

Pneumonia
Influenza
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) after G.B. with Stones
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Duck Butte
Did an operation precede death? No Date of 8/3/29
Was there an autopsy? No
What test confirmed diagnosis? Microscope
(Signed) H C Dow, M. D.
8/9, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt Morah	8-10 1929
20. Undertaker	Address
Schumacher & Baskey	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67151

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 261
(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5631

2. FULL NAME Jess McAllister

(a) Residence. No. — St. 31
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Colored
5. Single, Married, Widowed, or Divorced (write the word) unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 42 Years Months Days Near as known If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) unknown

PARENTS
10. NAME OF FATHER "
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant General Hospital
(Address) Pocatello Idaho

15. Filed 8/8, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8/5 — 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/5, 1929, to 8/5, 1929
that I last saw him alive on 8/5, 1929
and that death occurred, on the date stated above, at 6a m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of —
Was there an autopsy? yes
What test confirmed diagnosis? Tb. Lungs
(Signed) J. Young, M. D.
8/5, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View
Date of Burial Aug 29

20. Undertaker Schumacher & Reasby
Address City

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67152

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5630

(No. 137 South Second Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Benjaman Franklin Peffer

(a) Residence. No. 137 So. 2ND. Ave. Poca. Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

88B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) January 1, 1852

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
77	7	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10. NAME OF FATHER: Mike Peffer

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: McDermot

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Mrs. Gus Johnson
(Address) Wheatridge, Colo.

15. Filed 8/5, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 3, (Day) 1929. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

myocarditis
Found dead in his home.

(duration) yrs. mos. ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur W Hall Coroner M.D.

8/5, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Denver, Colorado.

Date of Burial: On Arrival 19

20. Undertaker: A. W. HALL

Address: POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67153

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2141
(No. Poca. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5629

2. FULL NAME Mary B. Ames

(a) Residence. No. 234 Washington Ave. Poca. Ida. St. 112
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: W.H.Ames

6. DATE OF BIRTH (month, day and year): August 5, 1894.

7. AGE: Years 35, Months 0, Days 13. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Clarkston, Utah.

PARENTS

10. NAME OF FATHER: Charles W. Butters
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Clarkston, Utah.
12. MAIDEN NAME OF MOTHER: Angeline Stewart
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Clarkston, Utah.

14. Informant: W. H. Ames
(Address) 234 Washington Ave. Poca. Ida.

15. Filed 8/20, 1929. J. Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 18, 1929. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 8/18, 1929, to 8/18, 1929
that I last saw her alive on 8/18, 1929
and that death occurred, on the date stated above, at 7 30 a m.
The CAUSE OF DEATH* was as follows:
Acute dilated Stomach
Following pneumonia
Hypostasis
(duration) ~~yrs.~~ ~~mos.~~ 3 ds.
CONTRIBUTORY (Secondary) Hypostasis
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Pocatello
Did an operation precede death? Yes Date of 8/15/29
Was there an autopsy? Yes
What test confirmed diagnosis? Usual
(Signed) H. C. [illegible], M. D.
8/19, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clarkston, Utah. Date of Burial: 8/20/29 19

20. Undertaker: Arthur W Hall Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 22 1929

PLACE OF DEATH

County of Bannock.

City of Pocatello.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

DO NOT WRITE IN THIS SPACE

State File No. 67154

Local Registrar's No. 5628

Between Declo Ida. & Pocatello Idaho. (on bus.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Joseph Alma Sessions.

(a) Residence. No. Salt Lake City, Utah. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Myra Newell.

6. DATE OF BIRTH (month, day and year): Nov. 23. 1854.

7. AGE: Years 74 Months 8 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Illinois.

PARENTS

10. NAME OF FATHER: Thomas B. Sessions.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Sarah Haws.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois.

14. Informant: Mrs. Martha La Rocque. (sister)
(Address) Blackfoot, Idaho.

15. Filed 7/29, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July. 27. 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Senility - Myocarditis
nephritis.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) [signature], M. D.

7/28, 1929. (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Heber City, Utah.

Date of Burial: 19

20. Undertaker: A. W. Hall.

Address: Pocatello Ida.

RECEIVED AUG 22 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2/61

(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 67155

Local Registrar's No. 5627

2. FULL NAME Hildur M. Carlson

(a) Residence. No. 129 St. Blackfoot. Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Axel Robert Carlson

6. DATE OF BIRTH (month, day and year) October 27, 1879

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	9	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Olas P. Wickstrom

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Helen C. Lindquist

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant A. R. Carlson

(Address) Blackfoot, Idaho

15. Filed 7/29, 1929. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25, 1929, to July 28, 1929.
that I last saw her alive on July 27, 1929
and that death occurred, on the date stated above, at 11:20 A. m.

The CAUSE OF DEATH* was as follows:
Uremic coma (Chronic parenchymatous nephritis).

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetis mellitus

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Report urine examination.

(Signed) S. H. Hughart, M. D.

7/28, 1929 (Address) Pocatello, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Blackfoot, Idaho	7/30/29
20. Undertaker	Address
Hall Mortuary	Pocatello.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67156

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2141
Local Registrar's No. 5626
(No. ~~Helen Meader~~ Lynn Bros Lt.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Helen Meader
(a) Residence. No. West of City St. 161a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6. DATE OF BIRTH (month, day and year) July 24-29

7. AGE Years Months Days 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Ida

PARENTS
10. NAME OF FATHER W. S. Meader
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER May Hurrelle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wis

14. Informant W. S. Meader
(Address) Pocatello Ida

15. Filed 7/29, 1929 J. H. Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24, 1929, to July 29, 1929
that I last saw her alive on July 24, 1929
and that death occurred, on the date stated above, at 7.9 m.
The CAUSE OF DEATH* was as follows: premature Birth
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) premature Birth
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? phy finding
(Signed) J. H. Lynn, M. D.
7-29, 1929 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View
Date of Burial July 29 1929

20. Undertaker Schumacher & Beasley
Address City

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67157

PLACE OF DEATH

County of Pocatello
City of Pocatello (No.) Registration District No. 28
Primary Registration District No. 216
133 S. Hayes
Local Registrar's No. 5625
General Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jose Augudo

(a) Residence No. 133 S. Hayes St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 22 1880

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	5	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Employed at
(b) General nature of industry, business, or establishment in which employed (or employer) Phoenix Pool Hall
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10. NAME OF FATHER Joaquin Augudo
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spain
12. MAIDEN NAME OF MOTHER Vicenta Yvars
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spain

14. Informant Mrs May Augudo
(Address) 133 S. Hayes

15. Filed 7/29, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22, 1929 to July 28, 1929
that I last saw him alive on July 28, 1929
and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:
Operation for Cholelithiasis
Cholelithiasis
& empyema Gall Bladder
(duration) 6 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 7-24-29
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. A. Bybee, M. D.
7-29, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View	July 31 1929
20. Undertaker	Address
Schumacher & Kinsley	City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67158

Registration District No. 28
Primary Registration District No. 7161
Local Registrar's No. 6724

PLACE OF DEATH
County Bannock
City of Pocatello
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Alexander
(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Greek	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Greece

PARENTS
10. NAME OF FATHER Alexander
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Greece
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Greece

14. Informant A. A. Cornell
(Address) Deer Lodge Mont

15. Filed 7/27, 1929 J. H. Fanning Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7/24, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-24, 1929, to 7/24, 1929
that I last saw h[illegible] alive on 7/24, 1929
and that death occurred, on the date stated above, at 11:40 a.m.
The CAUSE OF DEATH* was as follows: Stab wound left chest with Butcher knife in Zanetis Lunch Cafe - at hands of Gus Athipis (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Guarre
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 7/24/29
Was there an autopsy? Upio
What test confirmed diagnosis?
(Signed) J. H. Fanning, M. D.
7/27, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View	July 28 1929
20. Undertaker	Address
Schumacher Crosby	City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67159

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2/61

Local Registrar's No. 5622

(No. End of South Main Street)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME J. F. Farrelly

(a) Residence. No. South Main St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day,
About	70			hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Peddler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant A.W.Hall Coroner

(Address) 451 West Lewis Poca. Ida.

15. Filed 7/20, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 17. 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Found dead in shack
Myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur W Hall Coroner

7/20, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	7/20/29.

20. Undertaker	Address
Arthur W Hall.	Pocatello

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67160

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 241
Local Registrar's No. 5620

(No. 453 So. Fourth Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Barbra Blanchard

(a) Residence. No. Robin, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 29, 1929.

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	1	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Eli D. Blanchard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Logan, Utah.
12. MAIDEN NAME OF MOTHER Hazel E. Wheeler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Clifton, Idaho.

14. Informant Eli D. Blanchard
(Address) Robin, Idaho.

15. Filed 7/18, 1929. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 18, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/15, 1929, to 7/18, 1929
that I last saw h[illegible] alive on 7/18, 1929
and that death occurred, on the date stated above, at 2[illegible]5 A m.
The CAUSE OF DEATH* was as follows:

Peritonitis
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) 2nd degree Burn.
Burnt By Hot Water Bottle
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Robin Ida.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination

(Signed) O. Bell, M. D.
7/18, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Robin, Idaho.	7/19/20 19

20. Undertaker	Address
A. W. Hall	Pocatello,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 2 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Sept. 24, 1929

O.F. Call

67160

Pocatello, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

E. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

Barbra Blanchard who died July 18, 1929 at Pocatello, Idaho.

Contributory cause of death given as "2nd degree Burn"
Information DESIRED in order to complete certificate.

Was a burning building involved? No
These deaths are separately classified.

PLEASE ANSWER BELOW

The child was burnt by a hot water bottle

Dr O F Call

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67161

PLACE OF DEATH
County of Bannock.
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161

Local Registrar's No. 518

(No. 1036 West Fremont St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Franklin Palmer.

(a) Residence. No. 1036 West Fremont St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Cynthia Stoddard.

6. DATE OF BIRTH (month, day and year) Jan. 8. 1871.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	5	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Brick-mason
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kaysville, (State or country) Utah.

PARENTS

10. NAME OF FATHER James Palmer.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Elizabeth Foxall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Mrs. John F. Palmer.
(Address) 1036 West Fremont St. (city)

15. Filed 7/12, 19 29 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 11. 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2, 19 29, to July 11, 19 29
that I last saw h-- alive on July 11, 19 29
and that death occurred, on the date stated above, at 18 55 P m.

The CAUSE OF DEATH* was as follows:
Chronic Gastric Ulcer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam.

(Signed) O. F. Hall, M. D.
7/17/29, 19 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Anthony, Idaho.	7/ 29. 19
20. Undertaker Anthony O. Hall	Address Poca. Ida.

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67162

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 241
(No. 242 - Wayne Ave)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 547

2. FULL NAME Martha M Clark

(a) Residence. No. 242 Wayne Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Laurence D Clark

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	11	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden Utah

PARENTS

10. NAME OF FATHER Daniel J Murdock
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden Utah
12. MAIDEN NAME OF MOTHER Martha Clark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ogden Utah

14. Informant Bishop Clark
(Address) Pocatello

15. Filed 7/12/29 J H Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to July 11, 1929
that I last saw h[illegible] alive on July 10, 1929
and that death occurred, on the date stated above, at 8 9 m.
The CAUSE OF DEATH* was as follows:
Epidemic Cerebro-Spinal Meningitis
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory test of Spinal fluid

(Signed) O F Lee, M. D.
7-12, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View	July 12 1929
20. Undertaker	Address
Arthur W Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67163

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5616
(No. Poc. General Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Shirleyann Rennison
(a) Residence. No. ..... St. 100 a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) September 5, 28
7. AGE Years — Months 10 Days 6 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Elmonte Calif.

PARENTS
10. NAME OF FATHER Walter Rennison
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Ruth Lofler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Walter Rennison
(Address) Elmonte Calif.
15. Filed July 11, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 11 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 7-10, 1929, to 7-11, 1929
that I last saw her alive on 7-11, 1929
and that death occurred, on the date stated above, at 1 a. m.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
Pneumococcic Meningitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Whooping Cough
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature] M. D.
July 11, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pico California — Date of Burial July 12 1929
20. Undertaker McHan Wendt Co. — Address Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67164

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 56 15
(No. 709 So. Third Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thelma May Lewis

(a) Residence. No. 709 So. Third Ave. St. 1000
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 30, 1910.

7. AGE	Years	Months	Days	If LESS than 1 day,
	18	11	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston, Utah.

PARENTS

10. NAME OF FATHER Albert Lealand Lewis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Smithfield, Utah.
12. MAIDEN NAME OF MOTHER Arvegine Comish
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant Albert L. Lewis
(Address) 709 So. Third Ave. Poca.

15. Filed 7/11, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 10, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to July 11, 1929, that I last saw her alive on July 10, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Double Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical findings

(Signed) [signature] M. D.
7/11/29 (Address) City

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	7/12/29

20. Undertaker A W Hall
Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67165

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2141
(No. R.R. Crossing No. Of City)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 5614

2. FULL NAME Sybil L. Walton

(a) Residence. No. No. Of Pocatello City, St. 1880
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 16, 1918.

7. AGE	Years	Months	Days	If LESS than 1 day,
	10	11	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) At Home and School
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Alpine, Wyoming.

PARENTS
10. NAME OF FATHER LaVern Walton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Auburn, Wyoming.
12. MAIDEN NAME OF MOTHER Lily Livingston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St. Anthony, Idaho.

14. Informant Mrs. Lily Walton
(Address) No. Of City

15. Filed 7/11, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 8, 1929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Skull fracture and other injuries but by train while riding in car (accidental)
... (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Arthur W. Hall Coroner M. D.
7/11, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	7/11/29 19
20. Undertaker Arthur W. Hall.	Address Pocatello

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67166

Registration District No. 28
Primary Registration District No. 216
Local Registrar's No. 5613

PLACE OF DEATH

County of Bannock
City of Pocatello
(No. R.R. Crossing No. Of City.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Donna L. Walton

(a) Residence. No. No. Of City. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

1880

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 28, 1923.

7. AGE	Years	Months	Days	If LESS than 1 day,
	6	5	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Thayne, Wyoming.

PARENTS

10. NAME OF FATHER: LaVern Walton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Auburn, Wyoming.
12. MAIDEN NAME OF MOTHER: Lily Livingston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): St. Anthony, Idaho.

14. Informant: Mrs. Lily Walton
(Address): No. Of City

15. Filed 7/11, 1929. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 8, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:
Skull fracture left by
R.R. train while riding in car
(accidental)
(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Arthur W Hall Coroner M. D.
7/11, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	7/11/29 19

20. Undertaker: Arthur W Hall. Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 22 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67167

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5612
(No. R.R. Crossing, No. Of City.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1880

2. FULL NAME Keith Leon Walton

(a) Residence. No. No. Of City. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 1, 1921.

7. AGE	Years	Months	Days	If LESS than 1 day,
	8	4	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) At Home and School.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hiawatha, Utah.

PARENTS

10. NAME OF FATHER LaVern Walton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Auburn, Wyoming.
12. MAIDEN NAME OF MOTHER Lily Livingston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St. Anthony, Idaho.

14. Informant Mrs. Lily Walton
(Address) No. Of City.

15. Filed 7/11, 1929. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 8, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ...m.
The CAUSE OF DEATH* was as follows:
Skull fracture hit by R.R. train while riding in car (accidental)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Arthur W. Hall, Coroner, M. D.
7/11, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	7/11/29 19
20. Undertaker	Address
Arthur W Hall	Pocatello

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67168

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 7141
(No. Poc. Gen Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5610

2. FULL NAME Albert Eswan

(a) Residence. No. 150 Wayne ave, St. 170
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 16.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50.	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Esker E. Haines
(Address) Pocatello, Idaho

15. Filed July 7, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/4, 1929, to 7-6, 1929
that I last saw h[e] alive on 7-6, 1929
and that death occurred, on the date stated above, at 1:15 P. m.
The CAUSE OF DEATH* was as follows:
Skull fracture
G. S. Wound Upper head
Self Inflicted - Suicidal
(duration) yrs. mos. ds.
CONTRIBUTORY Insanity
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 7/6 - 29
Was there an autopsy? yes
What test confirmed diagnosis? Clinical
(Signed) [signature] M. D.
7/7, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise Idaho	July 7 1929

20. Undertaker [illegible] McHan Address Pocatello,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6716

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 0609

PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hospitol.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel M. Yeoman

(a) Residence. No. 1316 No. Arthur, Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elsie Keyes.

6. DATE OF BIRTH (month, day and year) Dec. 31. 1871.

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	57	6	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Train Baggageman.

(b) General nature of industry, business, or establishment in which employed (or employer) O.S.L.Ry.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebraska.

PARENTS

10. NAME OF FATHER William Yeoman.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.

12. MAIDEN NAME OF MOTHER Mary Etta Brimmer.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois.

14. Informant Mrs. Samuel M. Yeoman. (wife)
(Address) 1205 East Center. St. Poca. Ida.

15. Filed 7/6, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July. 3. 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to July 3rd., 1929
that I last saw him alive on July 3rd, 1929
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of July 2nd. 1929
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. W. Forbes, M. D.
7-6-29, 19 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cem.	7/6/29. 19
20. Undertaker	Address
Arthur W. Hall	Pocatello,

rth

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67171

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 421 North Eighth Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5621

2. FULL NAME George E. Burrell

90

(a) Residence. No. 421 North Eighth Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emily Ball

6. DATE OF BIRTH (month, day and year) January 13, 1865.

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	6	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Pumpman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer City of Pocatello

9. BIRTHPLACE (city or town) (State or country) Millcreek, Utah.

PARENTS

10. NAME OF FATHER John Burrell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Paris, France.
12. MAIDEN NAME OF MOTHER Mary Phulcher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant Mrs. George E. Burrell
(Address) 421 N. 8TH. Ave. Poca. Ida.

15. Filed 7/20, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 18, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-10, 1929, to 7-18, 1929
that I last saw h alive on 7-18, 1929
and that death occurred, on the date stated above, at 8 9 m.
The CAUSE OF DEATH* was as follows: Cardio-Renal Insufficiency

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Physical & Laboratory

(Signed) O. F. Call, M. D.
7-20, 1929 (Address) O. F. Call

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	7/21/29.

20. Undertaker	Address
A W Hall	Pocatello

RECEIVED SEP 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67172

PLACE OF DEATH

County of Bannock

City of Lago

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 2161

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 162

2. FULL NAME Lee N Kendall

(a) Residence. No. Lago, Idaho. St. 189
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Myrtle Kendall

6 DATE OF BIRTH (month, day and year)

7 AGE 39 Years | Months ? | Days ? | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John C Sorenson

9 BIRTHPLACE (city or town) (State or country) Benjamin Ut.

PARENTS

10 NAME OF FATHER Rulon L Kendall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Springville Ut.

12 MAIDEN NAME OF MOTHER Jane Bills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Jordan Ut.

14 Informant John C Sorenson
(Address) Lago ~~Idaho~~ Idaho

15 Filed Aug 31, 1929 Mrs G. G. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 10 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Not at all, 19....,

that I last saw h..... alive on ....., 19....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Dragged and kicked to death by a saddle horse

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Joseph C Otte, M. D.

6-29, 1929 (Address) Grace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Lago | Date of Burial 19

20. Undertaker | Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67173

PLACE OF DEATH
County of Bear Lake
City of St Charles

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Sarah A Allred 74a

(a) Residence. No. St Charles Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of William L. Allred

6. DATE OF BIRTH (month, day and year) Aug 5 1850

7. AGE Years 79 Months 0 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER William Wilkes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Haines
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant E. W. Allred
(Address) St Charles Idaho

15. Filed , 19 Hannah J. Nelson a.n. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 9, 1929, to Aug 5, 1929
that I last saw her alive on on July 25, 1929
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:
Apoplexy

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) CO Moore, M. D.
8/7, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67171

PLACE OF DEATH
County of Bear Lake
City of Bloomington

Registration District No. 6-3
Primary Registration District No.
Local Registrar's No. 123

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ward Haddock 46 B

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of E. J. Haddock

6. DATE OF BIRTH (month, day and year) Dec. 8, 1870

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	8	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bloomington, Ida.

PARENTS

10. NAME OF FATHER Thomas Ward
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Ann Reese
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant Grace M. Haddock
(Address) Bloomington

15. Filed 8-30, 1929 Mrs. J. S. Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4, 1921, to Aug 29, 1921
that I last saw her alive on Aug 28, 1929
and that death occurred, on the date stated above, at 7:30 a. m.
The CAUSE OF DEATH* was as follows:
Myocarditis, Chronic
(duration) 8 yrs. mos. ds.
CONTRIBUTORY (Secondary) Asthma, Respiratory
(duration) 15 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Findings
(Signed) C O Moore, M. D.
Aug 29, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bloomington Ida	8-31 1929
20. Undertaker	Address
John Hulme	Bloomington Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67175

PLACE OF DEATH
County of Blaine Lake
City of Sharon
Registration District No. 53
Primary Registration District No.
(No.)
Local Registrar's No. 22

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vearl Ray Hymas 10

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Aug 27 1926

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3	0	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER Ray L Hymas
11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Belle Wallentine
13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Boyd Hansen
(Address)

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929, to Aug 27, 1929
that I last saw him alive on Aug 27, 1929
and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:
Post Diphtheric Paralysis
Edema of Larynx

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical findings

(Signed) C C Nixon, M. D.
Aug 28, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lanark	8-29 1929
20. Undertaker	Address
John Gamblin	Sharon Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67176

PLACE OF DEATH
County of Bear Lake
City of Bloomington

Registration District No. 63
Primary Registration District No.
(No.)
Local Registrar's No. 121

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wayne Brown Reese

(a) Residence. No. 10 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6. DATE OF BIRTH (month, day and year): April 21 1923

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	3	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: None

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: Lotwick L. Reese
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Francis Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wyoming

14. Informant: J. L. Reese
(Address): Bloomington Ida Idaho

15. Filed 8-30, 1929 Mrs. J. S. Skinner, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Diphtheria
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Culture
(Signed) C O Mecoye, M. D.
Aug 27, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bloomington Ida	July 28 19
20. Undertaker: John Hulme	Address: Bloomington Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FOR [illegible] RECEIVED AUG 15 1929

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 46

Primary Registration District No. 2123

(No. ....., ... St.)

File No. 67177

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margarett E. Prior 47

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. June (Month) 13 (Day) 1875 (Year)

7. AGE 54 Yrs. ..... Mos. 34 ds.

IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER Eli Pea

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Levina West

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. G. S. Williamson
(Address) Cheevelah Wash.

15. Filed 7-19 1929 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1929 to July 17 1929 that I last saw her alive on June 10 1929 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. A. Nelson M. D.

7/17 1929 (Address) Tekoa Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 6 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Tekoa Wash

DATE OF BURIAL July 19 1929

20. UNDERTAKER C. L. Schulerud

ADDRESS Tekoa Wn

FORM V. S. No. 2 D.M.

RECEIVED AUG 15 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 2123
File No. 67178
Registered No.

1. PLACE OF DEATH
County of Bonneville
City of Plummer Ida
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John G. Korte

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: American White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 4 (Day) 1866 (Year)

7. AGE: 63 Yrs. 3 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John G Korte

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Wilhelmina Schmidt

13. BIRTHPLACE OF MOTHER (State or Country): Saxony

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary P Korte
(Address) Plummer Ida

15. Filed July 3 1929 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18th 1929, to July 3rd 1929, that I last saw him alive on July 3rd 1929, and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Uremia - Complicated With Pneumonia

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) General Weakness.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hunnicutt M. D.
7/6 1929 (Address) Ashton, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairmont Cemetery Upkeep
DATE OF BURIAL: July 5 1929

20. UNDERTAKER: C. Krueger
ADDRESS: Plummer

RECEIVED SEP 9

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Benewah State Ida Registered No. 134
Township DeSmet or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Peter Griffo 31 67179

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 17 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	17	6	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Kootenai Ida

PARENTS
10 NAME OF FATHER Stanislaus Griffo
11 BIRTHPLACE OF FATHER (city or town) Coeur d'Alene
(State or country) Kootenai Idaho
12 MAIDEN NAME OF MOTHER Emma Joseph
13 BIRTHPLACE OF MOTHER (city or town) Spokane
(State or country) Kootenai Wash

14 Informant Stanislaus Griffo
(Address) Plummer Ida

15 Filed Aug. 16, 1929 John Post REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1928 to Aug 15, 1929,
that I last saw him alive on Aug 13, 1929
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) yrs. mos. ds.
CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted At home
If not at place of death?
Did an operation precede death? Yes Date of May 20-29
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. E. Nelson M. D.
8/16 1929 (Address) Tensed Ida

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
St. Joseph Ida.	Aug. 17 1929
20 UNDERTAKER C. L. Schubert	ADDRESS Tekoa, Wash

V. S. No. 98

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 9 1929

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

67180

1 PLACE OF DEATH
County Bennett State Idaho Registered No.
Township or Village Dr Smith or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Julia Ariffa
(a) Residence No. St., Ward. 101 B
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F
4 COLOR OR RACE Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 16, 1920

7 AGE Years 9 Months 3 Days 9 If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Reservation

PARENTS
10 NAME OF FATHER Louis Ariffa Jr
11 BIRTHPLACE OF FATHER (city or town) Coeur d'Alene
(State or country) Reservation
12 MAIDEN NAME OF MOTHER Mary Meydalen Lott
13 BIRTHPLACE OF MOTHER (city or town) Coeur d'Alene
(State or country) Reservation

14 Informant Louis Ariffa Jr
(Address) De Smet, Idaho

15 Filed Aug. 26, 1929 John Post
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1929, to Aug 26, 1929
that I last saw her alive on Aug 25, 1929,
and that death occurred, on the date stated above, at 12 45 m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Measles
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? Clinical
(Signed) J. A. Nelson, M. D.
19 (Address) Tekoa

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Aug De Smet Idaho
DATE OF BURIAL 8-27 1929

20 UNDERTAKER C. L. Schulerud
ADDRESS Tekoa Wa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1929

PLACE OF DEATH

County of Benewah

City of St Maries, Idaho.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67181

Registration District No. 32

Primary Registration District No. 2049

Local Registrar's No. 25

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas Moody

(a) Residence. No. ~~3 [illegible]~~ 17th + Main St. 192
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Wid

5a. ~~If married~~, widowed, ~~or divorced~~
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 17, 1859

7. AGE: Years 70 Months 1 Days 20 If LESS than 1 day, ... hrs. or ..... min.
June 17, 1859.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Robert C. Moody

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maine.

12. MAIDEN NAME OF MOTHER: Hannah Witham.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Maine.

14. Informant: Fred Elwell.
(Address) St Maries Idaho

15. Filed Aug 16th, 1929. Walter Boberg, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1929, to Aug 7, 1929
that I last saw him alive on Aug 6, 1929
and that death occurred, on the date stated above, at 6.30a m.

The CAUSE OF DEATH* was as follows: Starvation + dehydration

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Melancholia

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? G G Eafe

(Signed) ....., M. D.

8/8, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: St. Maries, Ida — Date of Burial: Aug 9 1929

20. Undertaker: Geo. Mitchell — Address: St. Maries

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67182

PLACE OF DEATH
County of Benewah
City of St Maries
Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 24
(No. St. Maries Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Richard

2. FULL NAME Raymond Cole

(a) Residence. No. 1 St & Main St. 197
(Usual place of abode) St Maries, Ida (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Iowa Frances Baxter

6. DATE OF BIRTH (month, day and year) Aug 22 - 1890

7. AGE Years 38 Months 11 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rooming house owner
(b) General nature of industry, business, or establishment in which employed (or employer) Managing own Rooming house
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Taylorville, Ill

PARENTS
10. NAME OF FATHER John Cole
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Adelia Drennen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs R. R. Cole
(Address) St. Maries, Ida

15. Filed Aug 16th, 1929 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1929, to Aug 4, 1929
that I last saw him alive on Aug 4, 1929
and that death occurred, on the date stated above, at 6 40 P. m.
The CAUSE OF DEATH* was as follows:
Gunshot wound three right chest, homicidal
..... (duration) ..... yrs. ..... mos. 3/4 hrs ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? None
What test confirmed diagnosis?
(Signed) D Cornwall, M. D.
8/5, 1929 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane Wn — Date of Burial Aug 9 1929

20. Undertaker Geo. Mitchell — Address St. Maries,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 7 1929

PLACE OF DEATH

County of Benewah

City of St. Maries

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 32

Primary Registration District No. 2079

(No. St. Maries Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67183

Local Registrar's No. 23

1929

2. FULL NAME Joseph Lafayette Gage

(a) Residence. No. 59 Bleecker St. Gloversville, New York

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	31	7	3	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant Marine

(c) Name of employer Unemployed

9. BIRTHPLACE (city or town) Johnstown

(State or country) Fulton County, New York

PARENTS

10. NAME OF FATHER Charles Gage

11. BIRTHPLACE OF FATHER (city or town) Johnstown

(State or Country) Fulton County, New York

12. MAIDEN NAME OF MOTHER Celeste Smith

13. BIRTHPLACE OF MOTHER (city or town) Johnstown

(State or Country) Fulton County New York

14. Informant Dr. C. A. Robins and his mother

(Address) St Maries Ida.

15. Filed Aug 16th, 1929 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 3 1929

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1929, to Aug 3, 1929

that I last saw him alive on Aug 3, 1929

and that death occurred, on the date stated above, at 5:10 P m.

The CAUSE OF DEATH* was as follows: Accidental - fell beneath freight train he attempted to board while in motion crushing right leg (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock of injury

(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Haugan, Mont.

Did an operation precede death? Yes Date of Amp. leg 8/3/29

Was there an autopsy? None

What test confirmed diagnosis? Clinical sign & Exam

(Signed) C. A. Robins, M. D.

8/5, 1929 (Address) St Maries, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation,~~ or Removal Fonda, New York — Date of Burial 19

20. Undertaker Geo. Mitchell — Address St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67184

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. Blackfoot City Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 154

2. FULL NAME Lillain E. Thomas

(a) Residence. No. So. Shilling St. 41
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lorenzo R. Thomas

6. DATE OF BIRTH (month, day and year) Dec. 20. 1871

7. AGE Years 57 Months 6 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER John Elliott
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Mathewman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant L. R. Thomas
(Address) Blackfoot, Ida.

15. Filed Aug 30 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to August 29, 1929
that I last saw her alive on August 29, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Septicemia
..... (duration) ..... yrs. 1 mos. ..... ds.
CONTRIBUTORY (Secondary) Infected teeth and tonsils
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F. W. Mitchell, M. D.
8/30, 1929 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cem. Date of Burial: 9-1-29 19

20. Undertaker: Modern Mortuary, Blackfoot. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67185

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Dolph Ziegler

(a) Residence. No. St. 88B
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Sep 12 1855

7. AGE: Years 73, Months 11, Days 10. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Wm Ziegler
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio Penn
12. MAIDEN NAME OF MOTHER: Mary Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn

14. Informant: A. A. Ziegler
(Address): [illegible]

15. Filed: Aug 31, 29 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to Aug 28, 1929
that I last saw him alive on Aug 28, 1929
and that death occurred, on the date stated above, at 4:45 p.m.
The CAUSE OF DEATH* was as follows:
Hypertension with Chronic Myocarditis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
✓ (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical Findings
(Signed) J. O. Hampton M. D.
8-31, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Home City Cemetery
Date of Burial: Sep 1st 1929

20. Undertaker: E. T. Peck
Address: Blackfoot

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67186

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 152

2. FULL NAME NINA DEITMAN

(a) Residence. No. 74 St. Amsterdam Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	WIDOW

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) [illegible]

7. AGE	Years	Months	Days	If LESS than 1 day,
56				hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Alto, Wisconsin

PARENTS

10. NAME OF FATHER Abraham Klumpers

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holland

12. MAIDEN NAME OF MOTHER Jane Leemkuil

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Holland

14. Informant Minnie Hayes Att.
(Address) Blackfoot Ida

15. Filed Aug 25 29 Mrs Walter E. Pabst
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 25th, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15th-1929 to Aug 25th-1929
that I last saw her alive on Aug 25th 1929
and that death occurred, on the date stated above, at 10:25 A m.

The CAUSE OF DEATH* was as follows:

Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Geo. Williams, M. D.
Aug 25th, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls. Ida.	19
20. Undertaker	Address
Modern Mortuary,	Blackfoot. Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67187

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 151

2. FULL NAME ALICE REES

(a) Residence. No. ..... St. SALMON, IDAHO
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): WIDOW

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 62 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) ----
(State or country)

PARENTS
10. NAME OF FATHER ----
11. BIRTHPLACE OF FATHER (city or town) ----
(State or Country)
12. MAIDEN NAME OF MOTHER ----
13. BIRTHPLACE OF MOTHER (city or town) ---
(State or Country)

14. Informant Grace A. Clippinger R.N.
(Address) Blackfoot, Idaho.

15. Filed Aug. 24 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 23rd, 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8th 1929, 19, to Aug 23rd, 1929, 19
that I last saw her alive on Aug 23rd 1929, 19
and that death occurred, on the date stated above, at 9:40P m.
The CAUSE OF DEATH* was as follows:

Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) G. D. Williams, M. D.
Aug 24th 1929, 19 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Idaho | Date of Burial 19

20. Undertaker: E. S. Rink | Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67188

PLACE OF DEATH

County of Bingham

City of Maryland

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 150

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Geddes England 74a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John England

6. DATE OF BIRTH (month, day and year) April 17 1845

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84	4	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Wellshire England

PARENTS

10. NAME OF FATHER: Donald Hope

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Liza Stone

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs C. M. England

(Address) Pocatello R 1 Idaho

15. Filed Aug 23, 1929 Mrs Walter E. Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11, 1929, to Aug 21, 1929 that I last saw her alive on Aug 21, 1929 and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy (duration) 1 yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Artero-sclerosis (duration) 10 yrs. ..... mos. .....

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W W Beck, M. D.

8/21, 1929 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Maryland Cemetery — Date of Burial: Aug 25 1929

20. Undertaker: E T Peck — Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67189

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121.

Primary Registration District No. 2194.

Local Registrar's No. 149

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth Virginia White

(a) Residence. No. Blackfoot R. F. D. No. 5 St. 162
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 6 1929

7. AGE Years | Months 6 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Blackfoot

PARENTS

10. NAME OF FATHER James Ira White

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idesa Mo.

12. MAIDEN NAME OF MOTHER Leona Beatrice Stewart

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ida.

14. Informant Leona Beatrice White
(Address) Blackfoot R. F. D. No. 5

15. Filed Aug 15, 1929 Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Aug 15, 1929 that I last saw her alive on Aug 14, 1929 and that death occurred, on the date stated above, at 8:30 a m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis (Acute)

..... (duration) ~~yrs.~~ mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W W Beck, M. D.

8/15, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Iron City Cemetery | Date of Burial: Aug 16 1929

20. Undertaker: E. T. Peck | Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67190

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. Southern Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 148

2. FULL NAME David Taylor

(a) Residence. No. Boise, Idaho St. Boise Idaho 44
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dont know

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dish washer
(b) General nature of industry, business, or establishment in which employed (or employer) Dont know
(c) Name of employer Dont know

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER John Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont know
12. MAIDEN NAME OF MOTHER Dont know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont know

14. Informant U. G. Mercer
(Address) Blackfoot Ida

15. Filed Aug 12, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 12th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29th, 1929, to Aug. 11, 1929, that I last saw him alive on Aug. 11, 1929, and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomache

Dont know (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Age

— (duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? Dont know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Geo Williams, M. D.

Aug. 12th, 1929 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Blackfoot Asylum Cem. Date of Burial Aug. 8 1929

20. Undertaker Mrs Edy. Blackfoot Ida Address

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67191

PLACE OF DEATH

County of Bingham
City of Blackfoot Idaho
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 147
(No. So. Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Emma Morgan

(a) Residence. No. American Falls St. American Falls, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Geo W. Morgan

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
48	"			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant A. G. Morgan
(Address) Blackfoot Idaho

15. Filed Aug 12, 1929 Mrs Clarice E. Valentine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 11 at 1 A.M. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 7th, 1929, to Aug 10th, 1929
that I last saw her alive on Aug 10th, 1929
and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Paralysis of Insane
Don't Know (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Operation on breast
cause unknown (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Don't know
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo. Williams, M. D.
Aug. 11, 1929 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
American Falls. Idaho.	19

20. Undertaker E. W. Davis Address American Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67191

Dr. G. Williams
Blackfoot

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

Special Agent, Bureau of Census.

In reference to the death certificate of:

Mrs. Emma Morgan who died Aug. 11, 1929
Cause of death given as "Paralysis of insane." "Operation on breast."

Information DESIRED in order to complete certificate.

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW

This patient was operated before she was brought to the institution and I do not know the condition. Her mind was supposed to have been affected by the shock of the operation and from the affects of the toxic poisons in her system and possibly from drugs used during her hospitalization during her recovery from operation. Of course all these things can only be assumed as we get no information at the time of receiving these patients. The diagnosis is the best that could be made under the circumstances.

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67192

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194

Local Registrar's No. 146

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Malcom Andersen

(a) Residence. No. Shelley Idaho St. 10
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Jan 27 1925

7. AGE: Years 2 | Months | Days 11 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farm
(c) Name of employer: Shelley Idaho

9. BIRTHPLACE (city or town) (State or country): Shelley Idaho

PARENTS

10. NAME OF FATHER: Andrew Jorgensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Alsie Malcom
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bloomington Ill

14. Informant: Mrs C Knight
(Address): Shelley Ida

15. Filed Aug 3, 1929 Mac Walton E. Parkes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 19 to Aug 2 19 29
that I last saw h— alive on Aug 1 19 29
and that death occurred, on the date stated above, at 12 00 Noon.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Cardiac Paralysis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Residence
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratories

(Signed) C. Cahill, M. D.
Aug 2 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shelley Idaho — Date of Burial: Aug 2nd 1929.
20. Undertaker: Clifford Hayes — Address: Idaho Falls, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67193

Local Registrar's No. 145

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

Registration District No. 121

Primary Registration District No. 2194

(No. SOUTH IDAHO INSANE ASYLUM)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME MAUD S ECKERT

(a) Residence. No. ..... St. Hill City Ida
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Amos Eckert

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER ---

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vandehei

12. MAIDEN NAME OF MOTHER ---

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vandehei

14. Informant Grace A. Clippinger - R.N.
(Address) Blackfoot, Ida

15. Filed Aug 1, 1929 Mott Patton E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 1st, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 1:15 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion due to acute mania

(duration) ? yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Dementia Paranoea

(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) M. E. Patrick acting Supt of State Insane Asylum
Aug 1st 1929 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain Home	19

20. Undertaker J. Peck Address Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67194

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 32

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME August Schmitt

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	German	Single

5a. If married, widowed or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant P. J. Griffith
(Address) Ketchum Idaho

15. Filed 9-1, 1929 R. H. Wright. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 9th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1929 to Aug 9, 1929
that I last saw h— alive on Aug 9, 1929
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Carcinoma of left side of face involving lower lip eye and all glands of neck.
(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Negative
(duration) ..... yrs. 3 mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) E. W. Watt, M. D.
Aug 9, 1929 (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ketchum Idaho	Aug 11 1929
20. Undertaker	Address
Harris & Amos	Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67195

Registration District No. 57
Primary Registration District No. 2025
Local Registrar's No. 31

PLACE OF DEATH

County of Blaine
City of Carey

(No. 161a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baird

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year): 7-24-29

7. AGE: Years | Months | Days | If LESS than 1 day, ½ hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country): Carey, Idaho

PARENTS

10. NAME OF FATHER: Ernest W. Baird
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Helen City Utah
12. MAIDEN NAME OF MOTHER: Florence E. Harris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Carey, Idaho

14. Informant: Florence E. Harris
(Address): Carey, Idaho

15. Filed 9-1, 1929 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-24, 1929, to 7-24, 1929
that I last saw h[illegible] alive on 7-24, 1929
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Premature birth
7 months
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) E. W. Pot, M. D.
7 25, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Carey, Idaho — Date of Burial: 7 26 1929
20. Undertaker — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 29 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67196

PLACE OF DEATH

County of Bonner
City of Hope

Registration District No. 80
Primary Registration District No. 2457

Local Registrar's No. 12

(No. 74a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nathan Gardner Sisson

(a) Residence. No. Hope, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma S. Sisson

6. DATE OF BIRTH (month, day and year) 1 4

7. AGE Years	Months	Days	If LESS than 1 day,
81	6	8	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Hartford, Conn.
(State or country)

PARENTS

10. NAME OF FATHER Samuel Gardner Sisson

11. BIRTHPLACE OF FATHER (city or town) Hartford, Conn.
(State or Country)

12. MAIDEN NAME OF MOTHER Civella Case

13. BIRTHPLACE OF MOTHER (city or town) Hartford, Conn.
(State or Country)

14. Informant Mrs. Emma Sisson
(Address) Hope, Idaho.

15. Filed July 8, 1929 John Larson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31, 1929, to June 3, 1929
that I last saw him alive on June 1, 1929
and that death occurred, on the date stated above, at 6. a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis with hypertension (duration) 16 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm F. Tyler, M. D.

June 5, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hope, Idaho	June 5th. 19
20. Undertaker	Address
Moone Mortuary,	Sandpoint, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67197

PLACE OF DEATH

County of Bonner
City of Priest River

CERTIFICATE OF DEATH

Registration District No. 85
Primary Registration District No. 2185
(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 30

2. FULL NAME Hattie Luella Butts

(a) Residence. No. St. 96 Marshfield, Ore.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herbert Butts

6 DATE OF BIRTH (month, day and year) March 10, 1865

7 AGE: Years 64, Months 5, Days 17 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown, Minnesota

PARENTS
10 NAME OF FATHER: Walter White
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: Slokem
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: H H Butts
(Address) Priest River, Ida.

15 Filed Aug 30, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August (Month) 27, (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1929, to Aug 26, 1929, that I last saw her alive on Aug 26, 1929, and that death occurred, on the date stated above, at 4:50 A. m.

The CAUSE OF DEATH* was as follows:
Cardio renal vascular disease
(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): Influenza
(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Marshfield Ore.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Signs
(Signed) J. A. Lower M. D.
Aug 27, 1929 (Address) Priest River Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Woodmen Cemetery
Date of Burial: Aug 30 1929

20. Undertaker: Moon Mortuary, Priest River, Ida
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67198

PLACE OF DEATH
County of Bonner
City of Laclede

Registration District No. 85
Primary Registration District No. 2185
Local Registrar's No. 29

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Johanna Fuller. 88.3

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. F. Fuller.

6. DATE OF BIRTH (month, day and year) June 17, 1879

7. AGE Years 50 Months 1 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10. NAME OF FATHER Thomas Lee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.
12. MAIDEN NAME OF MOTHER Theresa Rising
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant J. F. Fuller.
(Address) Laclede, Idaho.

15. Filed Aug 9, 1929 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 7, (Day) 1929. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5, 1929, to Aug 7, 1929
that I last saw her alive on Aug 7, 1929
and that death occurred, on the date stated above, at 4:30 P. m.
The CAUSE OF DEATH* was as follows:
Carcinomatosis + ~~Head~~
Myocarditis
unknown (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? clinical
(Signed) J. C. Lower, M. D.
Aug 9, 1929 (Address) Priest River, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Seneacquoteen Cemetery
Date of Burial Aug 9, 1929

20. Undertaker Moon Mortuary
Address Sandpoint, Ida.

RECEIVED MAR 22 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67198

Dr. R.A. Lower
Priest River

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:
Johanna Fuller who died Aug. 7, 1929
Cause of death given as "Carcinomatosis and Myocarditis."

Information DESIRED in order to complete certificate:

PLEASE STATE THE PRIMARY SEAT OF THE DISEASE.

PLEASE ANSWER BELOW:

I saw patient in last stages + can not answer above question

R A Lower MD

RECEIVED SEP 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67199

PLACE OF DEATH
County of Bonner
City of Priest River

Registration District No. 85
Primary Registration District No. 2185

Local Registrar's No. 28

(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gladys Lucile Woolf.

(a) Residence. No. ..... St. Spokane, Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Hale O. Woolf.

6. DATE OF BIRTH (month, day and year) Oct. 4, 1898.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
30	9	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chatfield. Minn.

PARENTS

10. NAME OF FATHER James F. Moore
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Elgin Ill.
12. MAIDEN NAME OF MOTHER Josephine Sklenar
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Austria.

14. Informant Mrs. M. S. Lindsay
(Address) Priest River, Ida

15. Filed Aug. 3, 1929. R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 3 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2, 1929, to Aug 3, 1929
that I last saw her alive on Aug 3, 1929
and that death occurred, on the date stated above, at 6 00 Am.

The CAUSE OF DEATH* was as follows:
Cardiac Renal disease
unknown (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY none
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical signs

(Signed) C. A. Lewis, M. D.
Aug 3, 1929 (Address) Priest River, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane, Washington	Aug. 5, 1929
20. Undertaker	Address
Moon Mortuary	Sandpoint, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67200

PLACE OF DEATH

County of Bonner

City of Colburn

Registration District No. 7

Primary Registration District No. 2155

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME John William Hustead

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna E. Hustead

6. DATE OF BIRTH (month, day and year) April 20, 1856

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	4	8	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rutledge Mo

PARENTS

10. NAME OF FATHER David Hustead

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Malinda Short

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant C. E. Hustead

(Address) Colburn, Idaho

15. Filed Aug 28, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 28, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 23 1929, to August 28 1929
that I last saw h~~im~~ alive on August 25 1929
and that death occurred, on the date stated above, at 9:10 A. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. E. Evans, M. D.

Aug. 28, 1929 (Address) Hamilton, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Westmond Cemetery	Aug. 29 1929
20. Undertaker	Address
Moon Mortuary	Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67201

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME Georgia Florence Barfuss

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 25, 1929

7. AGE Years | Months: 1 | Days: 28 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho

PARENTS

10. NAME OF FATHER Oscar E. Barfuss

11. BIRTHPLACE OF FATHER (city or town) Bancroft,
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Vivian Kjellen

13. BIRTHPLACE OF MOTHER (city or town) Plummer
(State or Country) Minn.

14. Informant Oscar Barfuss
(Address) Sand Point Idaho

15. Filed Aug 24, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 23, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend, 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:
Acute gastric indigestion
(duration) 3 hrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bloyd G. Wendle, M. D.
Sep Aug 24, 1929 (Address) County Physician Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pinecrest Cemetery | Date of Burial: Aug 24 1929

20. Undertaker: L. G. Moon | Address: Sandpoint

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67202

PLACE OF DEATH
County of Bonner
City of Sandpoint Ida.
Humbird Camp No 3

Registration District No. 7P
Primary Registration District No. 215

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Einar Hermanson

(a) Residence. No. 90 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 28 1852

7. AGE	Years	Months	Days	If LESS than 1 day,
	77	3	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer) Humbird Lbr Co
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Wilbert Nelson
(Address) Humbird Lbr Co Camp 3

15. Filed Aug 6, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 5th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend, 19 to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical History

(Signed) Floyd G. Watson M. D.
Aug 6, 1929 (Address) County Physician Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverside Park Spokane	Aug 9 1929
20. Undertaker Turnbull Co	Address sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67203

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No.

(No. 13)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Methow

(a) Residence. No. ... St. Priest River, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 65 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant L. E. Moon
(Address) Sandpoint, Idaho.

15. Filed Aug 5, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 3, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2, 1929, to Aug 3, 1929
that I last saw him alive on Aug 2, 1929
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Uremic coma

Unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Floyd E. Nesbit, M. D.
Aug 5, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Priest River Cemetery	Aug. 6, 1929
20. Undertaker	Address
Moon Mortuary	Sandpoint Ida

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 24 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67204

Registration District No. 13

Primary Registration District No. 2150

Local Registrar's No. 139

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME William Joseph Steely.

(a) Residence. No. 228 W-14 Street St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white.

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Steely.

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 76. Months 2 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Surveyor.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER William Steely.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Sarah J. Baker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Mrs Gertrude Sorensen
(Address) 199 So Capitol Ave. I. F.

15. Filed July 29, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19, 1929, to July 24, 1929 that I last saw him alive on July 24, 1929 and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows: Uraemia (Uraemic Coma)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic nephritis

..... (duration) ? yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

July 29, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Ida. Date of Burial: July 30 1929.

20. Undertaker: V. F. McHan. Address: Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 24 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67205

Registration District No. 13

Primary Registration District No. 21

Local Registrar's No. 131

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

122

2. FULL NAME Lee W. Louis

(a) Residence. No. 343 North Water St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Lee W. Harris

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 60 | Months 4 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Stockbuyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Chicago, Ill.

PARENTS

10. NAME OF FATHER: George Louis

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Prussia

12. MAIDEN NAME OF MOTHER: Anna Creese

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Ralph A. Louis
(Address) 343 No. Water

15. Filed July 27, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12th, 1929, to July 24th date of death, 1929 that I last saw him alive on July 24th, 1929 and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows: Cirrhosis of the liver (alcoholic)

Treated him for 12 days

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Enlarged hard Liver Bile & albumin in urine

(Signed) Thomas C Willson, M. D.

July 25th, 1929 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida | Date of Burial: July 28 1929

20. Undertaker: V. F. McHan | Address: Idaho Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67206

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 137

161a

2. FULL NAME Garth Curtschi

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 24, 1929

7. AGE Years Months Days 1 If LESS than 1 day, 12½ hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER John Curtschi
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Luella Halley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wyoming

14. Informant ~~[illegible]~~ John Curtschi
(Address) Idaho Idaho.

15. Filed July 26, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24, 1929, to July 25, 1929
that I last saw him alive on July 25, 1929
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:
Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis in mother

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H R Hatch M. D.
July 25, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Alta, Wyoming
Date of Burial: July 22 1929

20. Undertaker: Jack A. Wood
Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67207

Registration District No. 73 0
Primary Registration District No. 7
Local Registrar's No. 136

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
(No. I. C. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161A

2. **FULL NAME** Grant Curtschi

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 24, 1929

7. AGE — Years | Months | Days: 12 | If LESS than 1 day, 12 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER: John Curtschi
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Switzerland
12. MAIDEN NAME OF MOTHER: Sadie Talley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wyoming

14. Informant: John Curtschi
(Address): Shigon, Idaho

15. Filed July 26 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1929, to July 25, 1929
that I last saw h[illegible] alive on July 25, 1929
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Prematurity
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): nephritis m mother
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H R Hatch M D
July 25, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Alta Wyoming — Date of Burial: July 26 1929
20. Undertaker: Jack G. Ward — Address: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 24 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67208

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2100
Local Registrar's No. 130
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Allen Osborne Martin. 49

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 27.

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	0	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer): Scotland
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hugh C Martin

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Jane Watterson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland.

14. Informant: Margarette Butler
(Address) Idaho Falls.

15. Filed July 26, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1929 (Year).

17. I HEREBY CERTIFY, That I attended deceased from July 19, 1929, to July 24, 1929
that I last saw him alive on July 23, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Cancer of Prostate Island

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature] M. D.
7/26/29. 19 (Address) Ida Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Swan Valley Ida. Date of Burial: July 26 1929.

20. Undertaker: V. F. McHan Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 24 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2110

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67209

Local Registrar's No. 134

88B

2. FULL NAME Ada Margaret Ives

(a) Residence. No. Clayton, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: John F. Ives

6. DATE OF BIRTH (month, day and year): May 7, 1857

7. AGE: Years 72 | Months 1 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Brigham City Utah

PARENTS

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (city or town) (State or Country): ?

12. MAIDEN NAME OF MOTHER: Ada Matheson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14. Informant: Mrs. I. E. Gockett

(Address) Idaho Falls Idaho

15. Filed 9 30, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to June 28, 1929

that I last saw her alive on June 26, 1929

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) [signature] M. D.

June 29, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Weston, Idaho | Date of Burial: July 1 1929

20. Undertaker: Jack A. Wood | Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67210

PLACE OF DEATH
County of Bonneville.
City of Idaho Falls.

Registration District No. 73
Primary Registration District No. 214

Local Registrar's No. 133

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Addison Vincent Scott. 49

(a) Residence. No. 267 Ridge Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs A. V. Scott.

6. DATE OF BIRTH (month, day and year) January 14

7. AGE: Years 71, Months 6, Days 4. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Realtor.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Joseph Scott.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana.
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs A. V. Scott.
(Address) Idaho Falls Ida.

15. Filed July 20, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8, 1929, to July 18, 1929
that I last saw him alive on July 16, 1929
and that death occurred, on the date stated above, at 5.15 P m.
The CAUSE OF DEATH* was as follows: Carcinoma of the Pancreas.

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Same

(duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? yes, Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Operation March 13 29
(Signed) H D [signature], M. D.
July 19, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: July 22 1929.

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67211

PLACE OF DEATH

County of Bonneville Registration District No. 13

City of Idaho Falls Primary Registration District No. 2150

Local Registrar's No. 132

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Delroy Carter

(a) Residence. No. Ammon St. 182
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 18, 1927

7 AGE Years 2. Months 1 Days 29. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butte Mont.

PARENTS

10 NAME OF FATHER Frank Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Joseph Utah.

12 MAIDEN NAME OF MOTHER Alberta Foster.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Twin Bridges Mont.

14 Informant Frank Carter.
(Address) Ammon Ida.

15 Filed July 18, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July. (Month) 17 (Day) 1929. (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Drowning (accidental)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr B Gatten M.D.
July 17, 1929 (Address) coroner, Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Ammon Ida

Date of Burial: July 18 1929.

20. Undertaker: V. F. McHan

Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67212

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2107
(No. I. F. C. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 131

160

2. FULL NAME Ann Pyne
(a) Residence. No. Pyne, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): July 12, 1929
7. AGE: Years | Months | Days: 3 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Pyne, Idaho

PARENTS
10. NAME OF FATHER: James E. Pyne
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pyne, Idaho
12. MAIDEN NAME OF MOTHER: Erma Perry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pyne, Idaho

14. Informant: James E. Pyne
(Address): Pyne, Idaho
15. Filed July 16, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to July 15, 1929
that I last saw h[illegible] alive on July 15, 1929
and that death occurred, on the date stated above, at 9-30 P m.
The CAUSE OF DEATH* was as follows:
Icterus Neonatorum
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary): Possible Obstruction Choledochus
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Pyne
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Blood test
(Signed) [signature] M. D.
July 16, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pyne, Idaho — Date of Burial: July 16 1929
20. Undertaker: Jack A. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67213

Registration District No. 13
Primary Registration District No. 2 10
Local Registrar's No. 1 2 0

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
(No.) L. D. S. Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lee S. Godfrey
(a) Residence. No. Idaho Falls, Idaho St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ Melba Salisbury

6. DATE OF BIRTH (month, day and year) Feb. 10, 1905

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	6	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Anthony Idaho

PARENTS

10. NAME OF FATHER David R. Godfrey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Loretta McIntyre
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant David R. Godfrey
(Address) Idaho Falls, Idaho

15. Filed July 14 – 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 14, 1929
that I last saw h alive on July 14, 1929
and that death occurred, on the date stated above, at 10 A. m.
The CAUSE OF DEATH* was as follows:

Osteomyelitis tibia

(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Septicemia
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of July 8 1929
Was there an autopsy?
What test confirmed diagnosis? X-ray

(Signed) [illegible], M. D.
July 14, 1929 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rose Hill - Idaho Falls	July 16 1929

20. Undertaker Jack A. Wood Address Idaho Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 24 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 73 96

Primary Registration District No. 2/30

(No. L. D. S. Hosp.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67214

Local Registrar's No. 129

149c

2. FULL NAME Burnett Engebretsen

(a) Residence. No. ..... St. Lorenzo, Idaho.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced.

5a If married, widowed, or divorced
HUSBAND of (or WIFE of) Irene Engebretsen.

6 DATE OF BIRTH (month, day and year) March 28 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Making Ditches.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Noroway

PARENTS

10 NAME OF FATHER Burnette Engebretsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Christana Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Jennie Sessions

(Address) 409 N. Water Idaho Falls, Idaho.

15 Filed 8-1-, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 29 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to June 29, 1929, that I last saw h alive on June 28, 1929, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Auto accident

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? on highway

Did an operation precede death? yes Date of June 26, 29

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) [illegible], M. D.

8-1, 1929 (Address) Rigby

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Rigby, Idaho.	8/1/29

20. Undertaker [illegible]

Address Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67215

PLACE OF DEATH
County of Bonneville.
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. L. D. S. Hosp/)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 124

84

2. FULL NAME Emily Unis Walton.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. M
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced ~~XXXXXXX~~ (or) WIFE of Charles Thomas Walton.

6. DATE OF BIRTH (month, day and year) July 10, 1878

7. AGE: Years 50, Months 11, Days 7. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho.

PARENTS

10. NAME OF FATHER: Thomas Fox
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Charles T. Walton
(Address) Rigby, Idaho.

15. Filed July 12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3rd (Day) 1929 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to July 3, 1929
that I last saw her alive on July 3, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Cerebral Tumor
(duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Interstitial
Nephritis (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Rigby Id.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
....., 19..... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby, Idaho. Date of Burial: 7/5/29 19

20. Undertaker: A B Eckersell Address: Rigby

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67216

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

Registration District No. 19

Primary Registration District No. 2156

Local Registrar's No.

(No. Bonners Ferry Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Hoglan

(a) Residence. No. 161A St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 29-1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bonners Ferry Idaho

PARENTS

10. NAME OF FATHER Harlan Hoglan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) South Dakota

12. MAIDEN NAME OF MOTHER Violet Marguerite East

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spokane Wn

14. Informant Violet East

(Address) Bonners Ferry Ida

15. Filed May 30, 1929 E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 5-P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth
26 weeks -
Placenta Previa Marginalis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Paul Bowell, M. D.

May 29, 1929 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida	May 29 1929

20. Undertaker	Address
H.R. Crouch	Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67217

PLACE OF DEATH
County of Boundary Registration District No. 29
City of Bonners Ferry Primary Registration District No. 2156 Local Registrar's No.
(No. Bonners Ferry Hospital,
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Truman Lage

(a) Residence. No. St. Naples, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Lage

6. DATE OF BIRTH (month, day and year) July 16 - 1890

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	10	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Bridge Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Great Northern R.R. Co.

9. BIRTHPLACE (city or town) (State or country) S. Dakota

PARENTS

10. NAME OF FATHER Edgar Lage
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Lena Lage
(Address) Naples, Idaho

15. Filed May 25, 1929. E E Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to May 24, 1929.
that I last saw him alive on May 24, 1929.
and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:
Accidental death - fall.
Fracture of 2nd. & 7th. ribs on right
Epilepsy of right lung - hemorrhage -
Dislocation of left hip.
(duration) yrs. mos. 8 hrs.

CONTRIBUTORY (Secondary) Shock.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) E E Fry, M. D.
May 25, 1929 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rathdrum, Idaho — Date of Burial 19

20. Undertaker Cassidy Funeral Home — Address Rathdrum Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

PLACE OF DEATH

County of Boundary

City of Porthill

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 79

Primary Registration District No. 2156

DO NOT WRITE IN THIS SPACE

State File No. 67218

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Rhoda M. Austin

(a) Residence. No. St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Austin

6. DATE OF BIRTH (month, day and year) Dec 21, 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	5	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10. NAME OF FATHER Jackson Pinkston

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Mefford

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tennessee

14. Informant John Austin,

(Address) Porthill, Idaho.

15. Filed May 22, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 22, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 10:30P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History of Cardiac Disease

(Signed) Earl B. Ball M. D.

May 22, 1929 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Porthill, Idaho,	May 27, 1929

20. Undertaker	Address
H.R. Crouch Bonners	Ferry, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67219

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

Registration District No. 29
Primary Registration District No. 2156

Local Registrar's No.

(No.) 88 (B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Albert Worley

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of N. Elizabeth Worley.

6. DATE OF BIRTH (month, day and year) Sept. 26-1879

7. AGE: Years 49 | Months 7 | Days 24 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work City Marshal
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER David Worley.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. N. Elizabeth Worley.
(Address) Bonners Ferry, Ida.

15. Filed May 23, 1929 E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1929, to May 22, 1929
that I last saw him alive on May 22, 1929
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Pyelonephritis.
(duration) yrs. 5 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no. Date of
Was there an autopsy? yes.
What test confirmed diagnosis? Physical examination.
(Signed) E. E. Fry, M. D.
May 23, 1929. (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry. Date of Burial: May 24 1929

20. Undertaker: H. R. Crouch, Bonners Ferry. Address

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67220

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martin H. Boruff 156
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred, 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 14 - 1863

7. AGE

Years	Months	Days	If LESS than 1 day,
65	10	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10. NAME OF FATHER: T. J. Boruff
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Janetta Sears
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: Mrs. Mary Rush
(Address) Fairview, Mont

15. Filed 5/11, 1929. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May, 10, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29, 1929, to May 10, 1929
that I last saw him alive on May 10, 1929
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
General peritonitis
Origin not determined
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Abdomen opened for drainage - advanced state of peritonitis did not permit exploration to determine site of infection
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Moravia Idaho
Did an operation precede death? Yes Date of May 8-1929
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) R. M. Bowell, M. D.
May 11, 1929 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida
Date of Burial: May 12 1929

20. Undertaker: H. R. Crouch, Bonners Ferry
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 3 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67220

Dr. R.M. Bowell
Bonners Ferry

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Martin H. Boruff who died May 10, 1929
Cause of death given as "General peritonitis.XXX Origin not determined.

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Abdomen opened for drainage - The advanced state of peritonitis did not permit exploration to determine site of safe origin of infection.

R.M. Bowell

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67221

PLACE OF DEATH

County of Boundary
City of Bonners Ferry
Registration District No. 79
Primary Registration District No. 2154
Local Registrar's No.
(No.) 44
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emelia Swenson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.
(If nonresident give city or town and State) Sweden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Carl Eric Swenson.

6. DATE OF BIRTH (month, day and year) Mar. 4 - 1859.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	2	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Johanson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Herb. Carlson
(Address) Bonners Ferry, Ida.

15. Filed 5/10, 1929 E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 5, 1929, to May 9, 1929
that I last saw h alive on May 8, 1929
and that death occurred, on the date stated above, at 2 A m.
The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Examination and history.

(Signed) E. E. Fry, M. D.
5/10, 1929 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	May 11, 1929

20. Undertaker	Address
H. R. Cronch	Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Idaho ~~OREGON~~ STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

67222

RECEIVED AUG 12 1929

State Registered No. 79.

1 PLACE OF DEATH

County Boundry State Idaho Local Registered No. 2156.

Township ..... or Village ..... or

City Meadow Creek No. 24a St., ... Ward

(If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME John Walter Beard.

(a) Residence. No. Meadow Creek St., —

(Usual place of abode) (If nonresident, give city or town and state)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed or ~~divorced~~ (write the word)
M	White	Widower

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Rebecca. Beard.

6 DATE OF BIRTH (month, day and year) Aug 5-1849

7 AGE	Years	Months	Days	If less than 1 day, ... hrs. or ..... min.
~~80~~	79	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) St John N B Canada

(State or country)

PARENTS

10 NAME OF FATHER Jno A Beard.

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Barton

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country)

14 Informant ..... (Address) Meadow Creek Ida.

15 Filed May 7, 1929 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1929

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1929, to May 6, 1929, that I last saw h~~im~~. alive on ✓, 19....., and that death occurred on the date stated above, at 8 P m.

The CAUSE OF DEATH was as follows: Apoplexy.

..... (duration) ✓ yrs., ✓ mos., 1 days.

CONTRIBUTORY (Secondary) Cancer (Face)

..... (duration) 4 yrs., 1 mos., 1 days.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) A F H DeLespinasse M. D.

May 6, 1929 (Address) Eastport Ida

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Missoula, Mont.	
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67223

PLACE OF DEATH

County of Kootenai
City of Bonners Ferry
Registration District No. 79
Primary Registration District No. 2105
Local Registrar's No.
(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Franklin Kinnear

(a) Residence. No. St. Longview, Wn
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed or divorced
HUSBAND of Lillian Kinnear
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 20-1889

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	4	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Real Estate dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Endicott Wash.

PARENTS

10. NAME OF FATHER Pete Green
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mary Pepple
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs W. L Kinnear
(Address) Bonners Ferry Ida

15. Filed 5/31, 1929. E. E. Fry, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 2, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 12, 1929, to May 2, 1929.
that I last saw h[illegible] alive on May 2, 1929
and that death occurred, on the date stated above, at 11:55 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Valvular disease.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Longview, Wash.
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Physical Examination
(Signed) E. E. Fry, M. D.
5/31, 1929 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry Cemetery	May 6 1929
20. Undertaker	Address
A. R. Crouch	Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67225

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. Bonners Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

161a

2. FULL NAME Baby Cameron

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 25 - 1929

7. AGE Years Months Days If LESS than 1 day, 3½ hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bonners Ferry Idaho

PARENTS

10. NAME OF FATHER Robert Taylor Cameron
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bakersfield Cal.
12. MAIDEN NAME OF MOTHER Thelma Gardner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Harrison Ida.

14. Informant Thelma Cameron
(Address) Bonners Ferry Ida

15. Filed June 25, 1929 E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw her alive on June 25, 1929
and that death occurred, on the date stated above, at 4³⁰ m.
The CAUSE OF DEATH* was as follows:
Premature Birth
28 weeks -
(due to overactivity of mother)
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Ken Bowell, M. D.
June 25, 1929 (Address) Bonners Ferry

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida
Date of Burial: June 25 1929

20. Undertaker: S. R. Crouch
Address: Bonners Ferry

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67226

PLACE OF DEATH

County of Boundary

City of Bopeland

Registration District No. 79

Primary Registration District No. 2156

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Virgil Spalding,

189

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 25, 1923.

7. AGE: Years 5, Months 11, Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tekoa, Wash.

PARENTS

10. NAME OF FATHER Henry R. Spalding

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Ann Elizabeth Lipp

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Henry R. Spalding
(Address) Copeland, Idaho.

15. Filed 6/27/, 1929 E. E. Frey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Accidental Death
Dragged by a horse
Fractured skull.
Fracture cervical spine
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination of body
(Signed) Rin Bowell, M. D.
June 26, 1929 (Address) Bonners Ferry Ida Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Idaho.
Date of Burial: June 28 1929

20. Undertaker: H.R. Crouch, Bonners Ferry. Ida.
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67227

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No.
(No. Bonners Ferry Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John D. Wyrick

(a) Residence. No. St. 31
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 10 1886

7. AGE Years 42 Months 8 Days 24 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10. NAME OF FATHER Frank Wyrick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Rachel Burke
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Charles Wyrick
(Address) Bonners Ferry Ida

15. Filed Mar. 17 1929. E E Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1929, to Mar. 6, 1929
that I last saw him alive on Mar. 5, 1929.
and that death occurred, on the date stated above, at 2 A. m.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis -
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Physical examination.
(Signed) E E Fry, M. D.
3/7, 1929 (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bonners Ferry Ida
Date of Burial Mar. 9 1929

20. Undertaker H. R. Crouch
Address Bonners Ferry

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 1 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67228

PLACE OF DEATH

County of Boundary
City of Bonners Ferry
Registration District No. 29
Primary Registration District No. 2154
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wilbert Freemont Yahne 49

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Louise Yahne

6. DATE OF BIRTH (month, day and year): Aug. 25 - 1856

7. AGE: Years 72 | Months 7 | Days 2 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Saw Mill worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Huntington Indiana

PARENTS

10. NAME OF FATHER: Wm Yahne
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Mary McCammon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Mrs Louise Yahne
(Address): Bonners Ferry, Ida

15. Filed 3/28/1929 E E Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to March 27, 1929, that I last saw h in alive on March 27, 1929, and that death occurred, on the date stated above, at 7:25 P m.

The CAUSE OF DEATH* was as follows:
Cancer of Gall Bladder
(duration) 2 yrs. 4 mos. ds.
CONTRIBUTORY (Secondary) Cancer of Liver
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Mar 14-1929
Was there an autopsy? No
What test confirmed diagnosis? Exploratory Laparotomy

(Signed) Lee Bonnell, M. D.
March 28, 1929 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida	Mar 29 1929
20. Undertaker	Address
B. P. Crouch	Bonners Ferry Ida.

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67229

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace Marie Reifsteck a

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 3 - 1928

7. AGE Years Months 7 Days 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bonners Ferry Ida

PARENTS
10. NAME OF FATHER Chas Reifsteck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wis.
12. MAIDEN NAME OF MOTHER Mary Sears.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mont.

14. Informant Chas. Reifsteck
(Address) Bonners Ferry Ida

15. Filed 3/26/, 1929. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929, to Mar 26, 1929
that I last saw her alive on Mar 25, 1929
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Pertussis
(duration) yrs. mos. 30 ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) Rui Bourree, M. D.
Mar 26, 1929 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bonners Ferry Ida. Date of Burial Mar 27 1929

20. Undertaker H. R. Cronch Address Bonners Ferry

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67230

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2154
Local Registrar's No.
(No. Bonners Ferry Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jess L. Bennis
(a) Residence. No. St. Dover Idaho 187
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Bennis
6. DATE OF BIRTH (month, day and year): Sept. 14 - 1888
7. AGE: Years 40, Months 5, Days 14. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Saw Mill operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Buffalo Minn.

PARENTS
10. NAME OF FATHER: Norman A Bennis
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wis.
12. MAIDEN NAME OF MOTHER: Elizabeth Gray
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: Mrs Katherine Bennis
(Address): Dover Idaho
15. Filed 2/29/, 1929 E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb: 28th. 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Accidental death - Struck by fragment from broken flywheel in sawmill
Fatal hemorrhage from severed femoral artery
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? Yes - Examination of thigh -
What test confirmed diagnosis?
(Signed) Ann Bowell, M. D.
Feb 28, 1929 (Address) Bonners Ferry Ida Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sandpoint, Ida. Date of Burial 19
20. Undertaker: H. R. Crouch, Bonners Ferry. Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67231

PLACE OF DEATH
County of Boundary
City of Bonners Ferry
Registration District No. 29
Primary Registration District No. 2157
Local Registrar's No.
(No.) 488
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ambrose Clark DeLap.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 11 1852.

7. AGE: Years 76 | Months 8 | Days 17 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Ambrose C DeLap
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Ruth Andrews
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Mrs. G. C. DeLap
(Address) Bonners Ferry Ida

15. Filed 3/1/, 1929. E. E. Fry, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14, 1929, to Feb 28, 1929, that I last saw him alive on Feb 28, 1929, and that death occurred, on the date stated above, at 5:50 m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) Ambrose DeLap, M. D.
Mar 1, 1929 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry Ida — Date of Burial: Mar 1 1929

20. Undertaker: W. R. Crouch — Address: Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67232

PLACE OF DEATH
County of Boundary
City of Bonners Ferry
Registration District No. 29
Primary Registration District No. 9134
(No.) Bonners Ferry Hospital
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dell Bliss

(a) Residence. No. Porthill, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jamie Bliss.

6. DATE OF BIRTH (month, day and year) Sept. 22, 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	4	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant Mrs. Marie Bliss
(Address) Porthill, Idaho.

15. Filed Feb. 17, 1929 E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 2nd, 1929, to Feb. 16th, 1929
that I last saw him alive on Feb. 16th, 1929
and that death occurred, on the date stated above, at 9 A. m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic interstitial nephritis
(duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) E. E. Fry, M. D.
2/17/1929 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Porthill, Idaho	Feb. 19 1929

20. Undertaker	Address
H. R. Crouch	Bonners Ferry

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67233

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. Bonners Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

88B

2. FULL NAME John C. Nichols

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 72 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant
(Address)

15. Filed 2/13/, 1929 E. E. Fox Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1929, to Feb 11, 1929
that I last saw him alive on Feb 11, 1929
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocardial Insufficiency
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) Rin Bowree, M. D.
Feb 11, 1929 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry | Date of Burial: Feb 18 1929

20. Undertaker: H. R. Crouch | Address: Bonners Ferry

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67234

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

Registration District No. 79

Primary Registration District No. 2156

(No. Bonners Ferry Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Alemina Skaurud (Alemina Skaurud)

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 1 - 1856

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
72	10	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Vick

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Clarence Skaurud

(Address) Bonners Ferry

15. Filed 2/10/, 1929. Ida E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 5 hours yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Ray Bowell, M. D.

Feb 9, 1929 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry Ida

Date of Burial: Feb. 14 1929

20. Undertaker: H. R. Crouch, Bonners Ferry

Address

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67236

PLACE OF DEATH
County of Boundary
City of Leonia, Idaho.
Registration District No. 79.
Primary Registration District No. 2156.
Local Registrar's No.

(No. 1610)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Patrick James O' Donnell

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 29 - 1921.

7. AGE — Years | Months | Days | If LESS than 1 day, 6 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Leonia, Idaho.

PARENTS

10. NAME OF FATHER Henry Patrick O'Donnell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denver, Colo.
12. MAIDEN NAME OF MOTHER Myrtle Stonebreaker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Troy, Mont.

14. Informant Henry P. O'Donnell
(Address) Leonia, Idaho.

15. Filed Jan. 29, 1921. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Jan. (Day) 29th (Year) 1921

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on Jan 21, 1921,
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Prematurity.
(6 months)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mother sustained a fall
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?

(Signed) E. E. Fry, M. D.
Jan. 31, 1921 (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Leonia, Ida.	Jan. 29 1921.
20. Undertaker	Address
H.P. O'Donnell	Leonia, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 12 '29

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67237

PLACE OF DEATH
County of Boundary
City of Bonners Ferry
Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No.
(No.) 748
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carl Clans

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 14-1844

7. AGE	Years	Months	Days	If LESS than 1 day,
	84	1	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) East Prussia Germany

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Henry Tank
(Address) Bonners Ferry Ida

15. Filed Jan. 21st 1929. E E Ing Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 20 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1928, to Jan. 30, 1929.
that I last saw h~~im~~ alive on Jan. 30, 1929
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 30 ds.
CONTRIBUTORY (Secondary) arteri-sclerosis.
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Physical Examination
(Signed) E E Ing, M. D.
1/31/1929 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry,	Jan. 22 1929
20. Undertaker	Address
H. K. Crouch,	Bonners Ferry.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67238

PLACE OF DEATH
County of Boundry
City of Naples

Registration District No. 79
Primary Registration District No. 2156

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Otis Croy

204

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline Croy

6. DATE OF BIRTH (month, day and year): June 1, 1876

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
52	5	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Brown Timber Co

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Agnes Johnson
(Address): Troy, Montana

15. Filed 1/12/, 1929. E. E. Troy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 12th. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Sudden death
Chronic Myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? History of Cardiac Disease
(Signed) Ann Bowell, M. D.
Jan 12, 1929 (Address) Coroner Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sandpoint, Idaho.
Date of Burial: Jan. 15th 1929

20. Undertaker: Moon Mortuary
Address: Sandpoint, Idah

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67939

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 29
Primary Registration District No. 2154

Local Registrar's No.

(No.) 74a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martin J. Peterson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 5 mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Peterson

6. DATE OF BIRTH (month, day and year) Feb 1 1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	11	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS
10. NAME OF FATHER Andrew Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Margaret Crawford
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Mrs. Caroline Peterson
(Address) Bonners Ferry Ida

15. Filed 1/14/, 1929. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1929, to Jan 13, 1929, that I last saw him alive on Jan 12, 1929, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
5
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Idaho Falls.
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Physical Examination

(Signed) Ruth Bonnell, M. D.
Jan 14, 1929 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry	Jan 16 1929
20. Undertaker	Address
H. R. Crouch	Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67240

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

88 B

2. FULL NAME George Royer
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Royer

6. DATE OF BIRTH (month, day and year): Mar. 11 - 1858

7. AGE: Years 70, Months 9, Days 22. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs. Mary Royer
(Address) Bonners Ferry, Ida

15. Filed 1/31, 1929. E. E. Fry, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan., 1928, to Jan. 2, 1929
that I last saw him alive on Jan. 1, 1929
and that death occurred, on the date stated above, at 5 A m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis,
..... (duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) E. E. Fry, M. D.
Jan. 3, 1929 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida
Date of Burial: Jan. 4 1929

20. Undertaker: H. R. Crouch, Bonners Ferry
Address

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67241

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Paul Ashby

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 31 - 28

7. AGE Years Months Days 3 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bonners Ferry

PARENTS

10. NAME OF FATHER J. B. Ashby
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Emma Harvey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant J. B. Ashby
(Address) Bonners Ferry

15. Filed 1/31, 1929. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1929, to Jan. 2, 1929
that I last saw him alive on Jan. 2nd, 1929.
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage.
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no. Date of
Was there an autopsy? no.
What test confirmed diagnosis?
(Signed) E. E. Fry, M. D.
1/31, 1929 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bonners Ferry Ida
Date of Burial Jan 4 1929

20. Undertaker H. R. Crouch
Address Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67242

PLACE OF DEATH
County of Boundary
City of Bonners Ferry
Registration District No. 79
Primary Registration District No. 2157
Local Registrar's No.
(No. 1430)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Ora Higgins

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of C. F. Higgins

6. DATE OF BIRTH (month, day and year) Aug. 5, 1891

7. AGE	Years	Months	Days	If LESS than 1 day,
	37	11	22.	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS
10. NAME OF FATHER J. W. Higgins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Hannah McConkey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant C. F. Higgins
(Address) Bonners Ferry, Ida

15. Filed July 31, 1929. E. E. Fay Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1929, to July 30, 1929.
that I last saw h alive on July 30, 1929.
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Peritonitis, septic.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (Attempted abortion.)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of June 4, 1929
Was there an autopsy? No.
What test confirmed diagnosis? Drainage of peritoneal cavity.
(Signed) E. E. Fay, M. D.
July 31, 1929 (Address) Bonners Ferry

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry	Aug. 2 1929
20. Undertaker	Address
H. P. Crouch	Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67243

PLACE OF DEATH

County of Boundary
City of Bonners Ferry
Registration District No. 29
Primary Registration District No. 2154
Local Registrar's No.
(No.) Bonners Ferry Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME M. W. Skelton

(a) Residence. No. 1014 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 25 - 1853

7. AGE — Years: 73 | Months: 11 | Days: 29 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Butcher. Retired.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: Skelton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: George Skelton
(Address) Moyie Springs, Ida

15. Filed July 31, 1929. E. E. Fry, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to July 27, 1929, that I last saw him alive on July 21st, 1929, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:
Pneumonia - lobar -
(duration) ... yrs. ... mos. 6 ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Physical examination
(Signed) E. E. Fry, M. D.
July 31, 1929. (Address) Bonners Ferry.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida	July 29, 1929.
20. Undertaker	Address
W. R. Crouch	Bonners Ferry.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

PLACE OF DEATH

County of Canyon

City of Wilder

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67244

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 76

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Amos Smith Bratcher

(a) Residence. No. Wilder, Ida R#1 St. 44
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Ona Gertrude Bratcher

6. DATE OF BIRTH (month, day and year): Jan 7 1876

7. AGE: Years 53, Months 6, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Cama Co Tenn

PARENTS

10. NAME OF FATHER: Wm T. Bratcher

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Mary J Doset

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn

14. Informant: Mrs A. S. Bratcher
(Address): Wilder, Ida R#1

15. Filed 7-28 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1929, to July 25, 1929 that I last saw him alive on July 23, 1929 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma of liver

(duration) yrs. Several mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [signature], M. D.

7/26 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: July 27 1929

20. Undertaker: C. V. Peckham — Address: Caldwell Ida

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67245

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 77
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Betty Louise Mullikin

(a) Residence. No. .... St. ....
(Usual place of abode)
Length of residence in city or town where death occurred. .... yrs. .... mos. .... ds. How long in U. S., if of foreign birth? .... yrs. .... mos. .... ds.
(If nonresident give city or town and State)

N/A

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6. DATE OF BIRTH (month, day and year): Oct 1, 1928

7. AGE — Years: none; Months: ~~11~~ 9; Days: 24; If LESS than 1 day, ... hrs. or .... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer: none

9. BIRTHPLACE (city or town) (State or country): Caldwell, Ida.

PARENTS
10. NAME OF FATHER: Charles Mullikin
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ore.
12. MAIDEN NAME OF MOTHER: Jennie Snell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Chester Mullikin
(Address): Caldwell, Ida.

15. Filed 7-31-, 1929 — John S. Mayer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1929 to July 25, 1929 that I last saw her alive on July 25, 1929 and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows: Meningitis due to Whooping Cough.

(duration) .... yrs. .... mos. 2 ds.

CONTRIBUTORY (Secondary): Enteritis

(duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? Colburton, Ida.
Did an operation precede death? no Date of ....
Was there an autopsy? no
What test confirmed diagnosis? Spinal puncture

(Signed) C. M. Bales, M. D.
7-26-, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill Cemetery	July 26, 1929
20. Undertaker: Paul L. Case	Address: Caldwell, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67246

PLACE OF DEATH

County of Nanyon

City of Nampa

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 78

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Willie Urie

142

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of none

6. DATE OF BIRTH (month, day and year) May 29, 1925

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	1	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer none

9. BIRTHPLACE (city or town) (State or country) Vale, Ore.

PARENTS

10. NAME OF FATHER William Urie

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER Jessie Miller

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Colorado

14. Informant Jessie Urie
(Address) Nampa 128 no 9 ave

15. Filed 7-29-, 1929. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 27, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Drowning accidental (Drowning)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H. P. Andrews J. P. , M. D.
, 19 Justice of Peace
Address Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill cemetery	7-29 1929
20. Undertaker: Paul Case	Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67247

PLACE OF DEATH

County of .....

City of Ontario

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 79

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME May Barker

(a) Residence. No. New Meadows St. 117
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Barker

6. DATE OF BIRTH (month, day and year) Sept 22-1886

7. AGE: Years 32 Months 9 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) South Dakota

PARENTS

10. NAME OF FATHER Geo. Kirnman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Tilla Carlson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) So Dakota

14. Informant E. Garlick
(Address) Wilder Ida No 2

15. Filed 7-29-, 1929- John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15th, 1929, to July 27, 1929

that I last saw her alive on July 27th, 1929.

and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

appendicitis acute - gangrenous

..... (duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 7/15/29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. C. Conant, M. D.

7/28/29, 19.... (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wilder Idaho — Date of Burial: July 29 1929

20. Undertaker: C. W. Peckham — Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67248

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 80

(No. 131)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Russell Monroe Smith

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Minnie McCollum Smith

6. DATE OF BIRTH (month, day and year) May 17, 1856

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	2	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) rancher
(c) Name of employer none

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER Alexander Breckenridge Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Susan Elizabeth Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mae Smith
(Address) Caldwell, Ida.

15. Filed 7-31-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7-27, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to July 27, 1929
that I last saw him alive on July 27, 1929
and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:
Uremic Poisoning
Kidney Stone - Relieved
Coma - Continued
Obstruction (duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Enlarged Prostate
Stone in Kidney
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J. D. Frazer, M. D.
July 31, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill Cemetery	Aug. 1 1929
20. Undertaker	**Address**
Paul L. Case	Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67249

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 81

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Captain H.S. Back

101 B

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widower - Unknown

6. DATE OF BIRTH (month, day and year) March 4, 1837

7. AGE Years 92 Months 4 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Old Soldier
(b) General nature of industry, business, or establishment in which employed (or employer) at home now
(c) Name of employer at home

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Miss Sadie Evans
(Address) Caldwell, Ida.

15. Filed 7-31-, 1929. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7-28 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to July 28, 1929
that I last saw him alive on July 27, 1929
and that death occurred, on the date stated above, at 8 A m.
The CAUSE OF DEATH* was as follows:
Hy fr Stako Pneumonia & aya -

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) T D Farrer M. D.
7/31, 1924 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill cemetery
Date of Burial: 7-31 1929

20. Undertaker: Paul L. Case
Address: Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67250

PLACE OF DEATH
County of Canyon
City of Nilder - Idaho

Registration District No. 3
Primary Registration District No. 2005 -
Local Registrar's No. 82

(No. 1)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Barbara Elaine Lovejoy

(a) Residence. No. 12 Miles South west of Caldwell Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 7 1928

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	5	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell Idaho

PARENTS

10. NAME OF FATHER Lamont Lovejoy

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa,

12. MAIDEN NAME OF MOTHER Evelyn Watson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Lamont Lovejoy
(Address) Wilder Idaho

15. Filed 8-9-, 1929. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to July 9, 1929
that I last saw h[illegible] alive on , 19
and that death occurred, on the date stated above, at 10 [illegible] m.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
Epidemic
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Wilder
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Spinal fluid
(Signed) T W Schmidt, M. D.
8-8, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise Idaho,	Aug 9 1929
20. Undertaker	Address
Summers & Kirk	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 12 1929

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 1005

(No. ....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67251

Local Registrar's No. 64

2. FULL NAME Nannie A Ellis Greenlund

131

(a) Residence. No. 202 No. 8th St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of A. Greenlund

6. DATE OF BIRTH (month, day and year) Oct 26 1847

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	8	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant A. E. Sutton

(Address) Caldwell, Ida.

15. Filed 7-9-1929 John S. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 7-29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 7, 1929 that I last saw h-s- alive on July 6, 1929 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J. L. Case, M. D.

7/12, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	July 9-29

20. Undertaker	Address
Paul L. Case	Caldwell Ida

Cole

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67252

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 65

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Leslie Gibbens

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE~~ of Isabell Blanch

6. DATE OF BIRTH (month, day and year) June 4 1880

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min:
48	1	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Wm F Gibbens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER Eunice E Wilcox
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kalamazoo Mich

14. Informant Clarence L Gibbens
(Address) Caldwell Ida R#4

15. Filed 7-14-, 1929 John L. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929 to July 10, 1929
that I last saw him alive on July 10, 1929
and that death occurred, on the date stated above, at 11:10 P m.

The CAUSE OF DEATH* was as follows:
Gangrenous Appendix
Peritonitis
Uremia
(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of July 1-29
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W W Raley M. D.
8-12-, 1929 (Address) Caldwell, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	July 14 1929
20. Undertaker C W Peckham	Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67253

PLACE OF DEATH

County of Canyon
City of Caldwell,

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 67

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Curry Parrott

(a) Residence. No. Caldwell, Ida. R.F.D. #3 St. 41
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 23-1883

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
46	0	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Page Center, Iowa

PARENTS

10. NAME OF FATHER Lewis Parrott
11. BIRTHPLACE OF FATHER (city or town) (State or Country) France
12. MAIDEN NAME OF MOTHER Eliza Jane Dugan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Butler Co. Penna.

14. Informant J.D. Parrott,
(Address) Caldwell, Ida. R F D 3

15. Filed 7-12-1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 11-1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 7, 1929, to July 11, 1929
that I last saw him alive on July 1, 1929
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:
Gen'l Septicaemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pyorrhoea
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Acute appendix
Did an operation precede death? Yes Date of July 7.
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) S B Dudley, M. D.
7/12, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: July 13 1929

20. Undertaker: Paul L Case
Address: Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67254

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 9
Primary Registration District No. 2005
Local Registrar's No. 68
(No. 204)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Blanche Compton Hall

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chas R Hall

6. DATE OF BIRTH (month, day and year) 1881

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer W M Krawl

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10. NAME OF FATHER Peter Compton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Curtis Hall
(Address) Caldwell Idaho

15. Filed 7-14-, 1929 John H. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 11-29 19...
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Cardiac Embulus.

Fell dead while milking cow.
No inquest. (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? ... Date of ...
Was there an autopsy? No
What test confirmed diagnosis? Opinion of Co. physician.
(Signed) Paul L. Case, M. D.
July 11-29 19... (Address) Coroner. Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Roswell Cemetery	July 14-29
20. Undertaker	**Address**
Paul L. Case	Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67255

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 68

(No.) 74a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas M Bartlett

(a) Residence. No. Denver Colo St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	61			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant P.L.Case
(Address) Caldwell Ida

15. Filed 7-16-, 1929 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 13-29 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Apoplexy.
Found dead near Ry westof Nampa about 3 hrs after talking to a P F E man. (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Exposure
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Opinion of County Physician.

(Signed) Paul L. Case, M. D.
July 15-29 19 (Address) Coroner Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill Cemetery	7-16-29 19

20. Undertaker	Address
Paul L.Case	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

K.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67256

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 70

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alfred Millard McCarty

(a) Residence. No. 708 Everett St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mrs. Lou Ella McCarty

6. DATE OF BIRTH (month, day and year) Feb 27 1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	4	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Danville Mo.

PARENTS

10. NAME OF FATHER Geo. McCarty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Elsie Culpepper
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Ethel B. Ward
(Address) 808 Everett Caldwell Ida

15. Filed 7-21-, 1929 John S. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1929 to July 18, 1929
that I last saw ~~him~~ alive on July 18, 1929
and that death occurred, on the date stated above, at 8:35 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
3rd Stroke
(duration) yrs 2 mos.
CONTRIBUTORY (Secondary) Two Previous Hemorrhages
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) C. W. Kaley, M. D.
8-19-, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	July 21 1929

20. Undertaker C. W. Peckham Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67257

Local Registrar's No. 71

201

2. FULL NAME Maurice Oliver Albertson

(a) Residence. No. Caldwell R# 2 St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April-30-1912

7. AGE Years: 17 Months: 2 Days: 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Caldwell Idaho

PARENTS

10. NAME OF FATHER: Earl Albertson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canton Ind

12. MAIDEN NAME OF MOTHER: Rhoda Harvey

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Marrisville Ind

14. Informant: Earl Albertson
(Address) Caldwell Ida

15. Filed 7-22-, 1929- John S. Meyer - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16, 1929, to July 19, 1929

that I last saw him alive on July 19, 1929

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Fractured cervical vertebra - second

..... (duration) ..... yrs. ..... mos. 3 ds

CONTRIBUTORY (Secondary): fall

..... (duration) ..... yrs. ..... mos. ..... ds

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7/17/29

Was there an autopsy? no

What test confirmed diagnosis? Operation x

(Signed) [signature], M. D.

7/21, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill

Date of Burial: July 22 1929

20. Undertaker: N. Peckham

Address: Caldwell Ida

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67259

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
(No.) 1012
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 78

2. FULL NAME Mrs Mary Langford Caldwell

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of A V Caldwell

6. DATE OF BIRTH (month, day and year) Feb 25 1838

7. AGE	Years	Months	Days	If LESS than 1 day,
	91	4	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Clay County
(State or country) Ind

PARENTS

10. NAME OF FATHER Fielding Langford
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Ky
12. MAIDEN NAME OF MOTHER Sarah Kincaid
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Unknown

14. Informant Guy E Caldwell
(Address) Caldwell Idaho

15. Filed 7-21-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to July 19, 1929
that I last saw her alive on July 14, 1929
and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:
Hypo-stake Pneumonia
Feeble & nearly blind - fell in her home and fractured hip.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Eye - Fract Hyp -
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J D Graves M. D.
July 20, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill Cemetery	7-22-29 19

20. Undertaker	Address
Paul L Case	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

REC'D FEB 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67259

Dr. T.D. Farrer
Caldwell

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Mrs. Mary Lansford Caldwell who died July 19, 1929
Cause of death (contributory) given as "Fractured hip."

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO WAS INVOLVED PLEASE NAME THE PLACE WHERE THE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Dear Sirs - Feb 26-30

Place of injury. In home - Feble and nearly blind - Fell and fractured hip - Placed in bed died in few days - from Hypostatic Pneumonia - at her home Caldwell Idaho -

T D Farrer M D

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED AUG 12 1929

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

DO NOT WRITE IN THIS SPACE

State File No. 67260

Local Registrar's No. 44

(No. 6 8 0)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lilly Kammeyer

(a) Residence. No. Caldwell, Ida R#1 St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Housewife

6. DATE OF BIRTH (month, day and year) Dec 6 1887

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	7	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Tripoli (State or country) Iowa

PARENTS

10. NAME OF FATHER Henry Shellhorn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant William Kammeyer

(Address) Caldwell Ida R#1

15. Filed 7-28-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to July 24, 1929 that I last saw h- alive on July 24, 1929 and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxic goiter

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 7/24/29

Was there an autopsy? no

What test confirmed diagnosis Clinical symptoms

(Signed) W. D. Montgomery M. D.

7-25, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	7-28 1929
20. Undertaker C. V. Peckham	Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

PLACE OF DEATH

County of Canyon

City of Wilder

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67261

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 75

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Geo. Gordon McCaw. 96

(a) Residence. No. Wilder Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna McCaw

6. DATE OF BIRTH (month, day and year): July 15 - 1863

7. AGE: Years 66 | Months — | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Rancher.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: James Wm. McCaw

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Georgia.

12. MAIDEN NAME OF MOTHER: Amanda Gordon

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Georgia.

14. Informant: Anna McCaw
(Address): Wilder Ida

15. Filed 7-28-, 1929 John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-14, 1929, to 6-14, 1929

that I last saw him alive on 6-14-, 1929

and that death occurred, on the date stated above, at 6-P. m.

The CAUSE OF DEATH* was as follows:

Tumor on the Brain

Indefinite (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Influenza

Several Months (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Dr. W. L. Broadhurst, M.D.

July 25, 1929 (Address) Caldwell

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wilder Cem. | Date of Burial: 7/26 1929

20. Undertaker: C. V. Peckham | Address: Caldwell Ida

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67262

PLACE OF DEATH

County of Owyhee Co.
City of Shedville Ore

Registration District No. 3
Primary Registration District No. 2005
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 63

2. FULL NAME James Blenderwith Stevenson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 3 - 1886

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	0	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) William Hope Scotland

PARENTS

10. NAME OF FATHER Geo Stevenson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Mary Henderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Margaret P. Stevenson
(Address) Caldwell Ida 1108 Dokin

15. Filed 7-7-, 1929. John L. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1929, to , 19
that I last saw h alive on July 1st, 1929
and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:
Intestinal Toxemia
Cause unknown

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) W W Jordan Jr M. D.
, 19 (Address) Jordan Valley Oregon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: July 7 1929

20. Undertaker: C. R. Peckham — Address: Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67263

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 9
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

183

2. FULL NAME Loraine Borne Shipp Martin

(a) Residence. No. Owington, Ken St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ ~~(or)~~ WIFE of Ernest C. Martin

6. DATE OF BIRTH (month, day and year) June 23-1895

7. AGE: Years 34 | Months 1 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Emmence Kentucky

PARENTS

10. NAME OF FATHER: Ruben Henry Shipp
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Owington Kentucky
12. MAIDEN NAME OF MOTHER: Barbara Allen Borne
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: Ernest C. Martin
(Address) 2728 Field Ave Lewisville, Ken

15. Filed Sep 1, 1929 Lulu Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 16 1929 to Aug. 16 1929
that I last saw her alive on Did not see her alive 19
and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows: Shot-gun wound; entered at 2 to 3 dorsal vertebrae ranging to left & down; exit-left axillary region (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accidental gun in hands of husband (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) W. E. Waldrop, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Owington, Ken | Date of Burial: 19

20. Undertaker: C. V. Peckham | Address: Caldwell, Ida

RECEIVED SEP 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67264

PLACE OF DEATH
County of [illegible]
City of [illegible]

Registration District No. 7
Primary Registration District No. 1004
(No. Dewey Palace Hotel)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 99

49

2. FULL NAME Fred K. Bowen
(a) Residence. No. R.F.D. 5 St. Vancouver
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Ava Bowen

6. DATE OF BIRTH (month, day and year) May 3rd 1877

7. AGE 52 Years | Months 4 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Hart Cigar Co
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Philadelphia Penna

PARENTS

10. NAME OF FATHER: Walter S. Bowen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Lyda Knox
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Mrs. Ava Bowen
(Address) Box 289 - Van Couver, Wash.

15. Filed 9-13, 1929 Letha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11, 1929, to ....., 19..., that I last saw him alive on Sept 11, 1929 and that death occurred, on the date stated above, at about 10 P.m.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
(Had one previous spell 2 yrs ago)
..... (duration) ..... yrs. ..... mos. 3 hours ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? [illegible]
(Signed) [illegible], M. D.
[illegible], 19[illegible] (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Portland, Oregon | Date of Burial: 19

20. Undertaker: Wm. D. Talley | Address: Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67265

PLACE OF DEATH
County of Canyon
City of Middleton

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 95

(No.) 114
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ransler Henry Allen.

(a) Residence. No. Middleton St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 5 1915

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Myself Ida.

PARENTS

10. NAME OF FATHER J. H. Allen.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri.
12. MAIDEN NAME OF MOTHER Martha Wilson.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri.

14. Informant J. H. Allen.
(Address) Middleton Ida

15. Filed 9-12-, 1929 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5, 1929, to Sept 9, 1929, that I last saw him alive on Sept 9th, 1929, and that death occurred, on the date stated above, at 2-45 P. m.

The CAUSE OF DEATH* was as follows:
Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. W. Hamer, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Middleton Cem.	9-10 1929
20. Undertaker C. V. Beckham	Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67266

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 94

(No. 148 e)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Verla Stewart

(a) Residence. No. 336 27" st Ogden Utah St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 3 - 1924

7. AGE	Years	Months	Days	If LESS than 1 day,
	5	2	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden Utah

PARENTS

10. NAME OF FATHER Geo. S. Stewart
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Edith B Magee
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant Geo S Stewart
(Address) 336 27" St Ogden Utah

15. Filed 9-9-, 1929 John S. Meyers
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 7 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Head Crushed. Auto accident.
Accidental. On Highway 2 miles East of Caldwell, Ida.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Paul L. Case, M. D.
Sept 8-29 19 (Address) Coroner Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ogden Utah	19
20. Undertaker	**Address**
Paul L. Case	Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 28 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Paul L. Case

Caldwell, Idaho

Sept. 26, 1929

Dear [redacted] Sir:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with tho information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

E. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

Verla Stewart who died Sept. 7, 1929 at Caldwell, Idaho from Auto Accident.

Information DESIRED in order to complete certificate.

Please state whether the auto accident was in the city limits or on the public highway. These are seperately classified.

PLEASE ANSWER BELOW

On public hiway two miles east of Caldwell Ida

P. L. Case

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 14 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67267

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 93

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George A. DeWolff 57

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 8-8-1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	—	30	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hotel man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Clement DeWolf
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Frances C. Beecher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Conn

14. Informant Geo. DeWolf
(Address) Grangeville Idaho

15. Filed 9-11-, 1929. John P. Mayes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9-7-1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Diabetes -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Paul L. Case, M. D.
9-11-29, 19 (Address) Coroner Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wellington Kans	19

20. Undertaker Paul L. Case — Address Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67268

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 9 2

(No. 16) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Phillips

(a) Residence. No. 11th & 12th Nampa St. Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 8, 1899

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	9	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Henry A. Phillips
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nevada
12. MAIDEN NAME OF MOTHER Martha Ingman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Crystal, Idaho

14. Informant Mrs Martha Phillips
(Address) Nampa, Idaho

15. Filed 9-10-, 1929. John L. Mayer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 - 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Died in Convulsion
Probably suicide from
taking Strychnine.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Paul L. Cease, M. D.
9-10-29 19 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill cemetery	9-10-29

20. Undertaker — Address
Paul L. Cease — Caldwell Ida

RECEIVED SEP 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67269

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 91
(No. 710)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Hunter

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 19, 1915

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
14	4	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10. NAME OF FATHER L. Hunter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) L. ~~from~~ Brownsville, Texas.
12. MAIDEN NAME OF MOTHER Maud Richardson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Aberdene, Texas.

14. Informant L. Hunter
(Address) Caldwell Idaho

15. Filed 9-7-, 1929 John B. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9-6 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3, 1929, to Sept 6, 1929
that I last saw him alive on Sept 6, 1929
and that death occurred, on the date stated above, at 10 a.m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) ?
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? x
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) S. B. Dudley, M. D.
9/11, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	9-7-29

20. Undertaker ..... Address .....
Paine & Chase Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67270

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 90

(No. 1110 D)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas F. Berry

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 23 - 1869

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	9	6	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Teacher & farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Whitehorn (State or country) Tenn

PARENTS

10. NAME OF FATHER Elson Berry
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Frances Garst
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Geo. T. Berry
(Address) Arrow Rock Dam. Idaho

15. Filed 9-4-, 1929. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1929 to Aug 29, 1929
that I last saw h[illegible] alive on Aug 29, 1929
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows: Obstruction of Bowel (Volvulus)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 8/29/29
Was there an autopsy? No
What test confirmed diagnosis? Found at Operation

(Signed) [illegible] M. D.
9/3, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wilder Idaho	9-1-29

20. Undertaker [illegible] Address Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67271

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 9
Primary Registration District No. 1005
Local Registrar's No. 89

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Howard

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) —

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug-24-1929

7. AGE — Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9. BIRTHPLACE (city or town) Caldwell Ida
(State or country)

PARENTS

10. NAME OF FATHER S. G. Howard
11. BIRTHPLACE OF FATHER (city or town) Raswell Ida
(State or Country)
12. MAIDEN NAME OF MOTHER Averil Jordy
13. BIRTHPLACE OF MOTHER (city or town) S. G. Howard
(State or Country)

14. Informant
(Address) Caldwell Ida

15. Filed 8-25-1929 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to Aug 24, 1929
that I last saw him alive on Aug 24/29 19....
and that death occurred, on the date stated above, at 5.30a
The CAUSE OF DEATH* was as follows:
Compression of cord in utero
..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Breech
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) M. Montgomery, M. D.
Aug 24, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Canyon Hill
Date of Burial 8-24 1929

20. Undertaker C. V. Peckham
Address Caldwell Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67272

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 88

PLACE OF DEATH

County of Canyon
City of Caldwell
(No. 1010)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lenard Eugene Miller

(a) Residence. No. 624 Denver St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 11-1928

7. AGE Years	Months	Days	If LESS than 1 day,
1	3	12	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Nampa Idaho
(State or country)

PARENTS

10. NAME OF FATHER Lewis J. Miller
11. BIRTHPLACE OF FATHER (city or town) Tillamook Oregon
(State or Country)
12. MAIDEN NAME OF MOTHER Bernice Vasser
13. BIRTHPLACE OF MOTHER (city or town) Elgin Oregon
(State or Country)

14. Informant R J Miller
(Address) 624 Denver, Caldwell, Ida

15. Filed 6-25-, 1929 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug 21, 1929, to Aug 23, 1929
that I last saw him alive on Aug 23, 1929
and that death occurred, on the date stated above, at 6:10 P. m.

The CAUSE OF DEATH* was as follows:
Double Lobar pneumonia

(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Convulsions from enteritis (duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C. E. Winkenbergen M.D.
Aug 24, 1929 (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Aug 25 1929
20. Undertaker C. R. Peckham	Address Caldwell Ida

White

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67273

PLACE OF DEATH
County of Canyon
City of Wilder

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 1

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary L Hetrick

(a) Residence. No. Wilder Ida St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 11 1862

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	1	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Nurse
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tonica Ill.

PARENTS

10. NAME OF FATHER Ben Hetrick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.
12. MAIDEN NAME OF MOTHER Elizabeth Dixon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant J B Hetrick
(Address) Wilder, Ida

15. Filed 8-23-1929 John L. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21, 1929, to Aug 22, 1929
that I last saw her alive on Aug. 21, 1929
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:
Acute dilatation of heart
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Mitral Stenosis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) C. W. Whatenbarger M. D.
Aug 22, 1929 (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Tonica, Ill.	
20. Undertaker	Address
C. J. Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67274

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
(No. Caldwell Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 86

88B

2. FULL NAME Mahlon Roberts
(a) Residence. No. Fairfield Iowa St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Roberts

6. DATE OF BIRTH (month, day and year) Mch 1860

7. AGE 69 Years | Months 5 | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Pleasant Plain
(State or country) Iowa

PARENTS

10. NAME OF FATHER Moses Roberts
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Ohio
12. MAIDEN NAME OF MOTHER Aire Heston
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Indiana

14. Informant Merle Kirkpatrick
(Address) Caldwell Idaho

15. Filed 8-23-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17, 1929, to Aug 21, 1929
that I last saw him alive on Aug 21, 1929
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) several yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
8/22, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Fairfield Iowa | Date of Burial 19

20. Undertaker C. V. Peckham | Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67275

PLACE OF DEATH
County of Canyon
City of Notus

Registration District No. 3
Primary Registration District No. 2005
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 85

47

2. FULL NAME Eliza Dietrich.
(a) Residence. No. Notus St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 26 1854
7. AGE Years 74 Months 11 Days 19 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Germany
PARENTS
10. NAME OF FATHER Mantel
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Don't know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany
14. Informant Rosie Smith
(Address) Notus Ida
15. Filed 8-18, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 15 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1929, to Aug 15, 1929
that I last saw her alive on Aug 3, 1929
and that death occurred, on the date stated above, at 2-45 a.m.
The CAUSE OF DEATH* was as follows:
Carcinomatous breast
(duration) Two yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
8/27, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Canyon Hill — Date of Burial 8/16 1929
20. Undertaker G. V. Peckham — Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 14 1929

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

DO NOT WRITE IN THIS SPACE

State File No. 67276

Local Registrar's No. 84

(No. 167)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Jesenko

(a) Residence. No. [illegible] Homedale St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 31 29

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho

PARENTS

10. NAME OF FATHER John Wm Jesenko

11. BIRTHPLACE OF FATHER (city or town) Rock Springs
(State or Country) Wyo

12. MAIDEN NAME OF MOTHER Mary Cegnar

13. BIRTHPLACE OF MOTHER (city or town) Rock Springs
(State or Country) Wyo.

14. Informant John Wm Jesenko

(Address) Homedale Ida

15. Filed 8-10-1929 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to aug 8, 1929
that I last saw him alive on aug 7, 1929
and that death occurred, on the date stated above, at 10 8 m.

The CAUSE OF DEATH* was as follows:

Manasmus

(duration) yrs. mos. 9 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Robert E Sallee M. D.

aug 10, 1929 (Address) Wilder Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Ida	aug 10 1929

20. Undertaker	Address
J. M. Peckham	Caldwell Ida

RECEIVED SEP 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67277

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 83

PLACE OF DEATH
County of Canyon
City of Caldwell
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Slade

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 4, 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	3	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER William Slade
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Decelia
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) France

14. Informant Claud Slade
(Address) 1224 Belmont, City

15. Filed 7-15-, 1929 John B. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 13, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible], 1927, to July 13, 1929
that I last saw him alive on July 10, 1929
and that death occurred, on the date stated above, at 4 p m.
The CAUSE OF DEATH* was as follows:

[illegible]

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) [illegible]
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.
8/12, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Caldwell Canyon Hill	July 15, 1929
20. Undertaker Paul Case	Address Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6278

PLACE OF DEATH
County of Cassia
City of Oakley

Registration District No. 120
Primary Registration District No. 2199
Local Registrar's No. 16
(No. 420)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Laird Jenkins

(a) Residence. No. Oakley St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Dorcas Jenkins

6. DATE OF BIRTH (month, day and year): Oct. 24 1845

7. AGE: Years 83 | Months 9 | Days 6 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Scotland

PARENTS
10. NAME OF FATHER: James H Jenkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Janet Laird
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: D. E. Johnson
(Address): Burley Ida

15. Filed Aug 1st 1929 H. C. Nielson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 26, 1929, to July 30, 1929, that I last saw h-im alive on July 30, 1929, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
Bronchial Asthma
(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary): None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place Death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Charles B. Reymer M. D.
Aug 1, 1929 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Oakley Ida — Date of Burial: Aug-1 1929

20. Undertaker: D. E. Johnson — Address: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 22 1929

5064

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67279

PLACE OF DEATH
County of Cassia
City of Oakley
Registration District No. 120
Primary Registration District No. 249
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard Poulton 129

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Josephine Poulton

6. DATE OF BIRTH (month, day and year) March 20 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	5	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER William Poulton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Rasbas

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Josephine Poulton
(Address) Oakley Idaho.

15. Filed July 31, 1929 H. E. Olsen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30—, 1929, to July 31—, 1929
that I last saw him alive on July 31—, 1929
and that death occurred, on the date stated above, at — 7a m.
The CAUSE OF DEATH* was as follows:
Chronic nephritis
(duration) 5 yrs. — mos. — ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) C. H. Cooper, M. D.
Aug 2, 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Oakley Idaho	Aug. 2 1929
20. Undertaker D. E. Johnson	Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67280

PLACE OF DEATH

County of Cassia

City of Declo

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Gillett

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frances Gillett

6. DATE OF BIRTH (month, day and year) Sept. 29, 1869

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	9	27	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Samuel Gillett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Naom i Chapell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant L. C. Gillett
(Address) Declo, Ida.

15. Filed July 25, 1929 J. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to July 23, 1929
that I last saw him alive on July 22, 1929
and that death occurred, on the date stated above, at 9:55 a. m.
The CAUSE OF DEATH* was as follows:
Tuberculosis Bronchitis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hugh E Larsen, M. D.

July 24, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Brigham City Utah — Date of Burial: July 26 1929

20. Undertaker D. E. Johnson Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67281

PLACE OF DEATH
County of Cassia
City of Burley
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carrie Merrill

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ivan A Marrill

6. DATE OF BIRTH (month, day and year) Sept. 17 1887

7. AGE	Years	Months	Days	If LESS than 1 day,
	41	10	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Albion
(State or country) Idaho

PARENTS

10. NAME OF FATHER Charles M Grey
11. BIRTHPLACE OF FATHER (city or town) Missouri
(State or Country)
12. MAIDEN NAME OF MOTHER Sarah Stephenson
13. BIRTHPLACE OF MOTHER (city or town) Missouri
(State or Country)

14. Informant Ivan A Merrill
(Address) Burley Idaho.

15. Filed Aug 22, 1929 F. W. Reuter
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to July 20, 1929
that I last saw her alive on July 20, 1929
and that death occurred, on the date stated above, at 1 5: P. m.
The CAUSE OF DEATH* was as follows:
Acute Cardiac Dilatation
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Uremia Hemorrhage
(not puerperal case)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? clinical
(Signed) Dwight E. Dean, M. D.
July 24, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Albion Idaho. Date of Burial: July 22. 1929
20. Undertaker: D.E.Johnson Address: Burley

RECEIVED MAR 7 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67281

Dr. H.E. Dean
~~XXXXXXX~~ Burley

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

Special Agent, Bureau of Census.

In reference to the death certificate of:

Carrie Merrill whodied July 20, 1929
Cause of death given as "Acute Cardiac Dilitation." "Uterine Hemorrhage."

Information DESIRED in order to complete certificate.

PLEASE STATE WHETHER OR NOT THIS WAS A PUERPERAL CASE. no

PLEASE ANSWER BELOW

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67282

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Sherley Jean Meyer 177

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 11, 1923

7. AGE Years 5 Months 9 Days 7 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida

PARENTS
10. NAME OF FATHER John Meyer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holland
12. MAIDEN NAME OF MOTHER Jessie Martin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oakley Ida.

14. Informant John Meyer
(Address) Burley Ida

15. Filed 8-21-, 1929 F. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17, 1929, to July 18, 1929
that I last saw her alive on July 18, 1929
and that death occurred, on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:
Indest Bile
Septicemia.
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? symptoms.
(Signed) Ben Schultz, M. D.
July 19, 1929 (Address) Beni Rawson

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida
Date of Burial July 21 1929

20. Undertaker D. E. Johnson
Address Burley

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67283

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 2107

Primary Registration District No. 90

Local Registrar's No. 94

(No. Northern Idaho Sanitarium) 90

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Jenkins

(a) Residence. No. ..... St. Wardner, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 2 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unascertained

6. DATE OF BIRTH (month, day and year) February 14, 1875

7. AGE	Years	Months	Days	If LESS than 1 day,
	54	6	14	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Missouri
(State or country)

PARENTS

10. NAME OF FATHER Elijah Picker

11. BIRTHPLACE OF FATHER (city or town) Kentucky
(State or Country)

12. MAIDEN NAME OF MOTHER Rebecca Snider

13. BIRTHPLACE OF MOTHER (city or town) Missouri
(State or Country)

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino — Idaho.

15. Filed 9/28, 1929 W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 28, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26, 1927 to August 28, 1929
that I last saw her alive on August 27, 1929
and that death occurred, on the date stated above, at 4:15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease
(mitral regurgitation)

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Paranoia & paranoid condition (duration) ? yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Prior to admission

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) John Irvine McKelvey, M. D.

August 28, 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Ida	19
20. Undertaker W. A. Shaw	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67284

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No.
Primary Registration District No.
(No. 49)
Local Registrar's No. 99

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isabella Monroe McIntosh

(a) Residence. No. Home St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Alexander McIntosh

6. DATE OF BIRTH (month, day and year): Feb 16th 1854

7. AGE: Years 75 | Months 7 | Days 5 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Brucefield Ontario Canada

PARENTS

10. NAME OF FATHER: John Munro
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Hannah McKay
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: Sister
(Address)

15. Filed 8/26, 1929. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) — 24 (Day) — 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11, 1929, to Aug 23, 1929
that I last saw her alive on Aug 23, 1929
and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus
Long time
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Tuberculosis - Don't know
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms & Microscope
(Signed) M. Robertson, M. D.
8-24, 1929 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hill Cemetery	Aug 25 1929
20. Undertaker: W. R. Simon	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67286

PLACE OF DEATH

County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 91

2. FULL NAME Myrtle Heagy
(a) Residence. No. Orofino Hospital St. 149
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Femal
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sep 14 1901
7. AGE: Years 28, Months 10, Days 30; If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10. NAME OF FATHER: Larkin Parson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Cora Axtel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: C. E. Heagy
(Address) Orofino

15. Filed Aug 14, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Aug 13, 1929
that I last saw her alive on Aug 13, 1929
and that death occurred, on the date stated above, at 5.15 a m.
The CAUSE OF DEATH* was as follows:
Placenta Praevia Centralis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hemorrhage - following
Secondary Anemia (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Findings
(Signed) O M Husted M. D.
Aug 14, 1929 (Address) Orofino Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Central Ridge
Date of Burial: 8/15 19

20. Undertaker: W A Shaw
Address: Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67287

Registration District No. 90
Primary Registration District No. 2157
Local Registrar's No. 90

PLACE OF DEATH

County of Clearwater
City of Orofino
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cornelius S. Sullivan

(a) Residence. No. 90 St.
(Usual place of abode)
Length of residence in city or town where death occurred. 9 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

Harrison - Idaho -
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of #
(or) WIFE of #

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day,
	63	?	?	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Restaurant keeper & rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER Unascertained
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed Aug 12, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to Aug 10, 1929
that I last saw him alive on August 10, 1929
and that death occurred, on the date stated above, at 9.55 P m.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease
(mitral regurgitation)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholic psychosis, chronic
(duration) 10+ yrs. mos. ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs

(Signed) John Irvine McKelway, M. D.
August 10, 1929 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
No. Idaho San. Cemetery.	Aug. 12 1929
20. Undertaker	Address
F. A. Billberg, Hosp. Mt.	Orofino, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67288

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 99

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME J C Manning 92

(a) Residence. No. ..... Orofino Hospital St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) ~

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 52			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Clearwater Timber Co

9. BIRTHPLACE (city or town) ..... (State or country)

PARENTS

10. NAME OF FATHER ~
11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) ~
12. MAIDEN NAME OF MOTHER ~
13. BIRTHPLACE OF MOTHER (city or town) ..... (State or Country) ~

14. Informant Orofino Hospital
(Address) Orofino Ida

15. Filed 8-5-, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 4- (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29th, 1929, to Aug 4, 1929
that I last saw him alive on Aug 4, 1929
and that death occurred, on the date stated above, at 4:50 p. m.
The CAUSE OF DEATH* was as follows:

Mesenteric Thrombosis -

..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Compound Fracture of Femur - Industrial Accident
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Aug 4 - 29
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) O M Austad, M. D.
Aug 4, 1929 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Aug 6 1929
20. Undertaker	**Address**
W. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REC[illegible]D MAR 3 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67288

Dr.O.M. Husted
Orofino, Ida.

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

- -

In reference to the death certificate of:

L.E. Manning Who died Aug. 4, 1929
Cause of death given as "Mesenteric Thrombosis" "Compound fracture of femur."

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH? IF AN AUTO WAS INVOLVED PLEASE NAME THE PLACE WHERE THE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Industrial Accident

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67289

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2157
Local Registrar's No. 18
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Austin Blain Forsuch

(a) Residence. No. ..... St. Winona, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. 7 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed or divorced
HUSBAND of ✓
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) August 1913

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	0	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Co., Idaho

PARENTS

10. NAME OF FATHER Austin Forsuch
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania
12. MAIDEN NAME OF MOTHER Hilda Olsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minnesota

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed Aug 1 -, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26, 1929, to August 1, 1929, that I last saw him alive on July 31 - 1929, and that death occurred, on the date stated above, at 12.55 A. m.

The CAUSE OF DEATH* was as follows:
Exhaustion of psychosis

(duration) ✓ yrs. ✓ mos. 11 ds.

CONTRIBUTORY (Secondary) Manic depressive psychosis, manic type, following pneumonia.
(duration) ..... yrs. ..... mos. 11 ds.

18. Where was disease contracted if not at place of death? Prior to admission.
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs.

(Signed) John Irvine McKelvey, M. D.
August 1 1929 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kamiah Ida	8/2 1929
20. Undertaker	**Address**
W. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED AUG 12 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Elmore

City of Mt. Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34

Primary Registration District No. 2020

(No. ..... St.)

State File No. 67290

Local Registrar's No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roy Rivali

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M-

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word)

6. DATE OF BIRTH: Unknown - 1 (Month) (Day) (Year)

7. AGE: about 22 yrs - Yrs. Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer -

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Aguilar, Colo. ~~Unknown~~ -

10. NAME OF Father: Abram Rivali

11. BIRTHPLACE OF FATHER (State or Country): New Mexico ~~Unknown~~

12. MAIDEN NAME OF MOTHER: Lucianda Chavez

13. BIRTHPLACE OF MOTHER (State or Country): New Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Rivali

(Address) Aguilar, Colo. Box 555

15. Filed Aug 8 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 184 (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..., that I last saw h..... alive on ..... 19..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Caused by knife wounds inflicted by one of the following men Art Renquiro, José Corrillo, Elimio Gonzales Eberardo Gutierrez (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Grant E. Hughes Coroner ~~M. D.~~

7/29 1929 (Address) Glenns Ferry, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Mountain Home

DATE OF BURIAL: 7-30 1929

20. UNDERTAKER: G. S. Zacher

ADDRESS: Mt Home

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact st very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 12 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Elmore

City of Mt. Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34

Primary Registration District No. 2020

(No. ..... St.)

State File No. 67291

Local Registrar's No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry F. Rathje 49

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6. DATE OF BIRTH: April (Month) 30 (Day) 1851 (Year)

7. AGE: 78 Yrs. 2 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF Father: Rathje

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carolena Rathje
(Address) Mountain Home

15. Filed Aug 8 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1929 to July 11 1929, that I last saw him alive on July 10, 1929, and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Bladder

(Duration) ..... yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. E. Evans M. D.

7-15-1927 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Mt Home

DATE OF BURIAL: 7-13 1929

20. UNDERTAKER: G. S. Zacher

ADDRESS: Mt Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 – 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67293

PLACE OF DEATH
County of Elmore
City of Glenns Ferry Ida

Registration District No. 35
Primary Registration District No. 2021
(No. 164)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Bethe Catherine Turner

(a) Residence. No. Glenns Ferry St. Ida
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 3 1847

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	3	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10. NAME OF FATHER Deance (did not know given name)
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Turner
(Address) Glenns Ferry Ida

15. Filed 8-28, 1929 Mrs. Mary Sullivan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1929, to Aug. 27, 1929
that I last saw her alive on Aug. 27, 1929
and that death occurred, on the date stated above, at 7-30 P m.

The CAUSE OF DEATH* was as follows:
Senility
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Mitral regurgitation
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? What test confirmed diagnosis? Clinical

(Signed) J. W. Davis, M. D.
Aug. 27, 1929 (Address) Glenns Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. ~~Place of Burial, Cremation, or~~ Removal	Date of Burial
Shoshone Idaho	19

20. Undertaker	Address
G C Zacher	Mtn. Home Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67295

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129

Local Registrar's No. 12

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Flora Alice L Sherman 90

(a) Residence. No. Arco Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: wt
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: L. L. Sherman

6. DATE OF BIRTH (month, day and year): May 3, 1867.

7. AGE: Years 62 | Months 3 | Days 19 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Cedar County Missouri

PARENTS

10. NAME OF FATHER: Thom. B. Tonys
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Cedar County Missouri
12. MAIDEN NAME OF MOTHER: Sally A. Pyle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Cedar County Missouri

14. Informant: Oliver L. Sherman
(Address): Arco Idaho

15. Filed Aug. 24, 1929. T. C. Galt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1929, to Aug 22, 1929, that I last saw her alive on Aug 22, 1929, and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cholecystitis (duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clynical Symptoms

(Signed) W. H. Egbert M. D.
Aug. 24, 1929 (Address) Arco Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Arco Idaho	Aug. 25, 1929
20. Undertaker: Geo. R. Garner	Address: Arco, Ida.

RECEIVED SEP 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67296

PLACE OF DEATH

County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME Alexander Orland Beckstead

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (Write the word): married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Phebe Beckstead

6. DATE OF BIRTH (month, day and year): Apr. 22 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	4	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Gardening
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): South Jordon Utah

PARENTS

10. NAME OF FATHER: Thomas W. Beckstead
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Lydia Rose
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant: Phebe Beckstead
(Address): Preston Idaho

15. Filed 9-3, 1929 — Registrar: A. P. Cutler

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-20, 1929, to 8-31, 1929
that I last saw him alive on 8-31, 1929
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(duration) 9 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypostatic pneumonia
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. P. Cutler, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Whitney Idaho	Sept 3 1929
20. M. W. Hendricks Undertaker Preston Address	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67297

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hyrum Parley Workman

(a) Residence. No. 99 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Sophia M. Workman

6. DATE OF BIRTH (month, day and year) Feb. 8 1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	6	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake City Utah

PARENTS

10. NAME OF FATHER Hyrum P. Workman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nauvoo Ill.

12. MAIDEN NAME OF MOTHER Sarah Marinda Merrill

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Charleston Mass.

14. Informant Mar. Sophia Workman
(Address) Preston Idaho

15. Filed Aug 17 1929 A. E. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Never saw from Alive, 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:—
Angina Pectoris
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Eugene Hodges M. D.
, 1929 (Address) Preston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Aug. 1929
20. Undertaker M. W. Hendricks	Address Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67298

PLACE OF DEATH

County of Franklin
City of Fairview
Registration District No. 27
Primary Registration District No. 2119
(No. 129)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Wesley Breedlove

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Lucy N. Breedlove

6. DATE OF BIRTH (month, day and year) Aug 24 1863

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER Richard Breedlove
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Eliza Ann Butchel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Lucy N. Breedlove
(Address) Fairview Idaho

15. Filed Aug 31, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1929, to Aug 29, 1929, that I last saw him alive on Aug 28th, 1929, and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:
Rheumatism & Nephritis

(duration) 2 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) 3 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) G. W. Stalus, M. D.
Aug 29, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fairview Idaho	Aug. 31 1929

20. Undertaker M. W. Hendricks Address Preston Ida o

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67299

PLACE OF DEATH
County of Franklin
City of Weston

Registration District No. 27
Primary Registration District No. 2119
(No. 124)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Guy Henry Hebdon

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 6 1913

7. AGE	Years	Months	Days	If LESS than 1 day,
	16	2	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Thayne Wyo
(State or country)

PARENTS

10. NAME OF FATHER Enos Hebdon

11. BIRTHPLACE OF FATHER (city or town) Franklin Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Mary J Nelsen

13. BIRTHPLACE OF MOTHER (city or town) Oxford Idaho
(State or Country)

14. Informant Enos Hebdon
(Address) Weston Idaho

15. Filed Aug 30, 1929. A. P. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-17, 1929, to 8-27, 1929
that I last saw h[illegible] alive on 8-27, 1929
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Acute Diffused Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Infection of Frontal Sinus (duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) E S Milford, M. D.
8-29, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Utah	Aug 30 29

20. Undertaker	Address
M. W. Hendricks	Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67300

PLACE OF DEATH

County of Gem

City of Emmett

Registration District No. 6

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

124

2. FULL NAME Ruth S. Hillery

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) Married

6a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE~~ of R. D. Hillery

6. DATE OF BIRTH (month, day and year) Un

7. AGE Years Un Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Elmira
(State or country) Oregon

PARENTS

10. NAME OF FATHER John D. Shaw

11. BIRTHPLACE OF FATHER (city or town) Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Arabelle Stingley

13. BIRTHPLACE OF MOTHER (city or town) Mo
(State or Country)

14. Informant R. D. Hillery
(Address) Emmett Idaho

15. Filed Aug 4, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 4 1929
~~July~~ (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to Aug 4, 1929
that I last saw her alive on Aug 4, 1929
and that death occurred, on the date stated above, at 1 30 p m.

The CAUSE OF DEATH* was as follows:
acute nephritis with uraemia.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Ileocolitis probably of influenzal origin

(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinary findings

(Signed) R. N. Cummings M. D.

8-7-, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Dallas Ore. Polk Co.

Date of Burial 19

20. Undertaker C. D. Bucknum

Address Emmett Idaho

RECEIVED DEC 2 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

R.N. Cummings

Emmett, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

E. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

Ruth S. Hillery who died at Emmett, Idaho on Aug. 4, 1929.

Information DESIRED in order to ~~complete~~ certificate.

Date of birth and Age as to years, months and days

PLEASE ANSWER BELOW

The information you request is unobtainable here.

Very truly yours

R N Cummings

RECEIV 7 192

STATE OF IDAHO
PARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67301

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No. Q
Primary Registration District No.
Local Registrar's No.
(No. 304)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Moses Harvey Johnson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Edna Johnson

6. DATE OF BIRTH (month, day and year) Aug 1 - 1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	—	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Curtis H. Johnson
(Address)

15. Filed 8/12, 1929 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw him alive on ✓, 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Never saw him till after death
Sudden death —
Probable Apoplexia or Heart
Sudden (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY ✓
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? ~~Aut~~ Clinical

(Signed) J L Reynolds, M. D.
8/12, 1929 (Address) ✓

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Star Idaho	8/13 1929
20. Undertaker C D Buckenum	Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67302

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. 6
Primary Registration District No.
Local Registrar's No.
(No. 49)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John W. Ayers
(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Caroline Ayres

6. DATE OF BIRTH (month, day and year) Nov 18-1850

7. AGE	Years	Months	Days	If LESS than 1 day,
	78	5	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Elkhorn Indiana

PARENTS

10. NAME OF FATHER James Ayers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER — Carr
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mrs J. W. Ayers.
(Address) Emmett Idaho

15. Filed 7/14, 1929 J. R. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9th, 1929, to July 13, 1929
that I last saw her alive on July 14, 1929
and that death occurred, on the date stated above, at 9. a. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of bladder
with hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. R. Reynolds, M. D.
7/14 1929 (Address) Emmett Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 7/14 1929

20. Undertaker: C. D. Buckmun — Address: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67303

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. 6
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ninzie A. Corbin 88B

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Cynthia Corbin

6. DATE OF BIRTH (month, day and year) Sept 8 - 1851

7. AGE Years 77 Months 10 Days 27 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS
10. NAME OF FATHER Benjamin Corbin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant W. L. Corbin
(Address) New Plymouth Ida

15. Filed 8/6, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY That I attended deceased from of an on for 1926 months, 19
that I last saw him alive on about a month ago
and that death occurred, on the date stated above, at A. m.
The CAUSE OF DEATH* was as follows: Dead in bed in morning
Myocardial disease
aortic stenosis with
dilitation
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sclerosed arteries
age (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. L. Reynolds, M. D.
8/6, 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho
Date of Burial: 8/6 1929

20. Undertaker: C. D. Buckneum
Address: Emmett Idaho

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67304

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Jean Stanley
(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 6 - 1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Emmett
(State or country) Idaho

PARENTS

10. NAME OF FATHER H. C. Stanley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Effie Crowley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant H. C. Stanley
(Address) Emmett Ida

15. Filed 8/8, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6, 1929, to Aug 7, 1929
that last saw h[illegible] alive on Aug 7, 1929
and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:
Birth injury & suffocation
High forceps delivery - Gallowy
Shoulder caught.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) [illegible]
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. L. Reynolds, M. D.
8/8, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Ida	8/8 1929

20. Undertaker	Address
C. D. Buckmon	Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67305

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No.
Primary Registration District No. 6
Local Registrar's No.
(No. 2)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Susan Elizabeth Wright
(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	white	widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 6 - 1849

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	6	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER Gasnell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) not known
12. MAIDEN NAME OF MOTHER not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) not known

14. Informant A M Wright
(Address) Emmett Idaho

15. Filed Aug 24, 1929 J K Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1928, to Aug 1929, that I last saw her alive on July 20, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Complicated / Myocarditis
several yrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J K Reynolds, M. D.
8-24, 1929 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	8/25 1929

20. Undertaker C D Buckmun
Address Emmett Idaho

FORM V. S. [illegible] RECEIVED SEP 10 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 67506
Registered No. 104

1. PLACE OF DEATH
County of Gooding
City of Gooding (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Un named) Pauls
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Aug (Month) 8 (Day) 1929 (Year)

7. AGE: ... Yrs. ... Mos. ... ds.
IF LESS than 1 day how many 10 hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gooding Idaho

10. NAME OF FATHER: Erwin Pauls

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Elizabeth Stanwood

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Erwin Pauls
(Address) Gooding Ida

15. Filed 8-31- 1929 J H Comwell
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 161a
Aug (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-8- 1929 to 8-9- 1929
that I last saw h[illegible] alive on 8-9- 1929
and that death occurred on the date stated above, at 6 a. M.
The CAUSE OF DEATH* was as follows:
Premature birth
gestation period 6 mths
Cause Unknown
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) 10 hrs
(Duration) ... yrs. ... mos. ... ds.
(Signed) J H Cromwell M. D.
8/9 1929 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding | DATE OF BURIAL: 8-10- 1929

20. UNDERTAKER: C E Thompson | ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 10 1929

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 67307
Registered No. 85

1. PLACE OF DEATH.
County of Canyon
City of Huston Rt 1
(No. ....., ... St.)
Registration District No. 7
Primary Registration District No. 2006

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Eliza Cole

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed
6. DATE OF BIRTH: Dec 20 1846 (Month) (Day) (Year)
7. AGE: 82 yrs. 8 mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Woodbridge Co Ind
10. NAME OF FATHER: Isaac Decory
11. BIRTHPLACE OF FATHER (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Sarah White
13. BIRTHPLACE OF MOTHER (State or Country): Indiana
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W D Cole
(Address) Huston Ida Rt 1
15.
Filed 8-15 1929 Stella Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 14 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1929, to Aug 14 1929
that I last saw h[illegible] alive on Aug 14 1929
and that death occurred on the date stated above, at 1 A.M.
The CAUSE OF DEATH* was as follows:
Myocarditis Chronic
Arterial Sclerosis —
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) age -
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J S Frazer M. D.
8 14 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn — DATE OF BURIAL: Aug 15 1929
20. UNDERTAKER: Wm D Talley — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67308

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
(No. mile east of Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 86

2. FULL NAME Alex Henry Alexander Weddle 49
(a) Residence. No. mile east Nampa St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet Weddle

6. DATE OF BIRTH (month, day and year) July 17 - 1863

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
66	0	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: contractor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10. NAME OF FATHER: Alexander Weddle
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penna (name since changed)
12. MAIDEN NAME OF MOTHER: Susanah Weddle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs. Harriet Weddle
(Address) Nampa, Idaho

15. Filed 8-8, 1929 Tertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1929, to Aug 6, 1929
that I last saw him alive on Aug 6, 1929
and that death occurred, on the date stated above, at 2 A m.
The CAUSE OF DEATH* was as follows:
Cancer of bladder
(Carcinoma)
(duration) 1 yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) I only administered relief for last few days
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? his life
Did an operation precede death? yes Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J H Murray, M. D.
Aug 8, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa
Date of Burial: 8-8 1929
20. Undertaker: Wm D. Talley
Address: Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67309

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
(No. Mercy Hosp't)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 87

2. FULL NAME Kenneth W. Weaver 41
(a) Residence. No. 7 miles south of Nampa
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 12-1917

7. AGE Years 11 Months 11 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Inschool
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clackamas Co. Ore.

PARENTS
10. NAME OF FATHER Audubon L. Weaver
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Audubon Iowa
12. MAIDEN NAME OF MOTHER Cora E. Sprague
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant A. L. Weaver
(Address) R#4 Nampa Ida

15. Filed 8-4, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1-29, 19..., to Aug 3-, 1929
that I last saw him alive on Aug 3-, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Septicemia due to Bacillus aerogenes Capsulatus.
..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cultures
(Signed) Samuel A. Swayne M. D.
Aug 6, 1929 (Address) Nampa, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Caldwell Ida. Date of Burial 8-5-1929

20. Undertaker Fred K Robinson Address Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67311

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1606
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 59

2. FULL NAME Edith Johnson

(a) Residence. No. 120 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, ~~Married~~, ~~Widowed~~, or ~~Divorced (write the word)~~
Fem	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6. DATE OF BIRTH (month, day and year) June 10 - 1917

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
12	1		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls
(State or country) Ida

PARENTS

10. NAME OF FATHER Geo. L. Johnson

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Julia Crandall

13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)

14. Informant Geo. L. Johnson
(Address) Nampa, Ida

15. Filed 8-7, 1929 Bertha Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26, 1929, to Aug 4, 1929
that I last saw her alive on Aug 4, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute peritonitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Ruptured Appendicitis

(gangrene) (duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Yes Mercy Hosp
Did an operation precede death? Yes Date of Nampa
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Grace B Bethurum M. D.
8-4, 1929 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Ida	8-7 1929
20. Undertaker F. K. Robinson	Address Nampa Ida

B

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1929

PLACE OF DEATH

County of Canyon

City of

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 2006

(No. 122)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67312

Local Registrar's No. 90

2. FULL NAME Thomas Ward

(a) Residence. No. about 10 miles so.east. St. Nampa Kuna, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Ward.

6. DATE OF BIRTH (month, day and year): Feb. 5th 1847

7. AGE — Years: 82 — Months: 6 — Days: 3 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England.

PARENTS

10. NAME OF FATHER: William Ward

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England.

12. MAIDEN NAME OF MOTHER: Susan Ritchie

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England.

14. Informant: Mrs George Ward

(Address): Kuna, Idaho

15. Filed 8-9, 1929 Retha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1929, to July 21, 1929

that I last saw h alive on July 21, 1929

and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

General failure - Was kind for 3 years - Sclerosis of the liver Complicated by Mitral Insufficiency (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) F. J. Coleman, M. D.

8-8, 1929 (Address) Kuna Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa — Date of Burial: 8-9 1929

20. Undertaker: Wm D. Talley — Address: Nampa, Ida.

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67313

PLACE OF DEATH
County of Canyon
City of

Registration District No. 7
Primary Registration District No. 2006
(No. 3½ mi. west Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 91

159B

2. FULL NAME Freddie Merle Daniel
(a) Residence. No. 3½ miles West Orchard Ave. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) Aug. 11th 1929
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Nampa Idaho

PARENTS
10. NAME OF FATHER R. L. Daniel
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark.
12. MAIDEN NAME OF MOTHER Pearl Overbey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ark.

14. Informant Mr. R. L. Daniel
(Address) Nampa, Idaho
15. Filed 8-12, 1929 Tritha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 11 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on Aug 11, 1929
and that death occurred, on the date stated above, at 10:30 P m.
The CAUSE OF DEATH* was as follows:
Congenital heart
Chest Breathed
or Force (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Breech presentation
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [illegible], M. D.
8-12, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kohlerlawn-Nampa
Date of Burial 8-12 1929
20. Undertaker Mrs. Nina M. Tafley
Address Nampa, Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67314

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 92
(No. Infant son of Mr & Mrs Harry Wood)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME
(a) Residence. No. 804-10 Ave So. Nampa St. 161a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years ✓ Months ✓ Days ✓ If LESS than 1 day, 16 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nampa Ida

PARENTS
10. NAME OF FATHER: Harry W. Wood
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ashere Iowa
12. MAIDEN NAME OF MOTHER: Virile Thmorley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Harry W. Wood
(Address) Nampa Ida.

15. Filed 8-12, 1929 Bertha Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible], 1929, to 8-12-, 1929
that I last saw him alive on Aug 12, 1929
and that death occurred, on the date stated above, at 7 a m.
The CAUSE OF DEATH* was as follows:
Premature birth (7½ M)
Imperfect heart action (Blue body)
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) V C Beelandt M. D.
8-12, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Boise Ida
Date of Burial: 8-13 1929

20. Undertaker: Fred. K. Robinson
Address: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1929

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 1006

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67315

Local Registrar's No. 93

2. FULL NAME Mennah N. Mock

(a) Residence. No. 7 ave + 2d st S St. 74a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem.

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of F. G. Mock

6. DATE OF BIRTH (month, day and year) June 7-1869

7. AGE Years 60 Months 2 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Hubert Nettleton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Emeline Crow

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant F. G. Mock

(Address) Nampa Ida

15. Filed 8-14, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13, 1929, to Aug 13, 1929 that I last saw her alive on Aug 13, 1929 and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

6 hrs.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Christian Science 4 hrs.

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) G. F. Ross, M. D.

Aug 14, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kohlulawn Cem

Date of Burial 8-18 1929

20. Undertaker F. K. Robinson

Address Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67316

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. 623-17th Ave. So)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 94

2. FULL NAME Josie Johnson

44

(a) Residence. No. 623-17th Ave. So St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of James M. Johnson

6. DATE OF BIRTH (month, day and year) January 31st 1859

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lone Jack Missouri

PARENTS

10. NAME OF FATHER James Sanders
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Mary Yankee
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Mrs. J. L. DeWitt
(Address) 623-17th Ave. So. Nampa

15. Filed 8-24, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 23rd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Aug 23, 1929
that I last saw her alive on Aug 23, 1929
and that death occurred, on the date stated above, at 4:15 a.m.
The CAUSE OF DEATH* was as follows:
Cancer of stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. C. Nolte M.D., M. D.
Aug 24, 1929 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohleslawn-Nampa
Date of Burial: 8-25 1929

20. Undertaker: Mrs. Nina M. Talley
Address: Nampa, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67317

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 95

125

2. FULL NAME Rose Urban
(a) Residence. No. 424-17th Ave. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joe Urban

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE: Years 43 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Albert Janousek
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bohemia
12. MAIDEN NAME OF MOTHER Anna Spicka
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bohemia

14. Informant Mr. Joe Urban
(Address) 424-17th Ave. N. Nampa

15. Filed 8-31, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 29th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 922, 19..., to her death, 19...
that I last saw her alive on Aug 29, 19..
and that death occurred, on the date stated above, at 10:30 P. m.
The CAUSE OF DEATH* was ~~as follows:~~ acute pancreatitis and local peritonitis with exhaustion following operation for [illegible]
(duration) ..... yrs. ..... mos. 8 ds.
CONTRIBUTORY (Secondary) Chronic chol cyst [illegible]
(duration) 5 8 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of Aug 21, 29
Was there an autopsy? no
What test confirmed diagnosis? visual
(Signed) Dr Proctor Kellogg M. D.
8-31-29, 19.. (Address) Geo R Proctor Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kofferlawn - Nampa. Date of Burial: 8-31 1929

20. Undertaker: Mrs. Nina M. Talley Address: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67218

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
(No. 803 - 10th St. So.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 96

2. FULL NAME Alonzo Beaman 90

(a) Residence. No. 803 - 10th St. So. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Emma Jean Beaman

6. DATE OF BIRTH (month, day and year) August 22nd 1841

7. AGE: Years 88 | Months | Days 7 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Antwerp New York

PARENTS

10. NAME OF FATHER: David Beaman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mass.
12. MAIDEN NAME OF MOTHER: Sally Ann Mosher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mass.

14. Informant: Mr. J. J. Beaman
(Address) Berkeley, California

15. Filed 9-3, 1929 Leetta Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 29th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-9, 1929, to 8-29, 1929
that I last saw him alive on 8-25, 1929
and that death occurred, on the date stated above, at 4:30 P. m.
The CAUSE OF DEATH* was as follows:

Heart failure

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
Senility (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. C. Hunter M. D.
9-3, 1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn, Nampa. Date of Burial: 9-3 1929
20. Undertaker: W. M. Talkey Address: Nampa, Ida.

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67319
Local Registrar's No. 72

PLACE OF DEATH
County of Canyon
~~City of~~ Rural
Registration District No. 7
Primary Registration District No. 2006
(No. ____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Emmett W. Wilson

(a) Residence. ~~No.~~ 7½ Miles N.E. Nampa St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) 2-18-1855

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	6	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER —
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Mary Wise
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant C. B. Wilson
(Address) Homedale, Ida.

15. Filed 9-1, 1929 Bertha Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 25, 1929, to August 27, 1929
that I last saw him alive on Aug 27, 1929
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ____ yrs. ____ mos. 7 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 10? yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? X
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis? Clinical

(Signed) S. B. Dudley, M. D.
Aug 30, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa, Idaho	9-1 1929
20. Undertaker	Address
F. K. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67320

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 98

164

2. FULL NAME Thomas Guynn

(a) Residence. No. 414 15 ave. S St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 14 1839

7. AGE 90 Years | Months -- | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10. NAME OF FATHER: Thomas Guynn
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: ~~Maryxxxxx~~ Jane Lytle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Frank Guynn
(Address) Nampa Ida

15. Filed 9-1, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 31 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1924, to Aug 31, 1929
that I last saw him alive on Aug 30, 1924
and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:
No disease nor any particular organ affected. He died of exhaustion due to age (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Geo R. Proctor, M. D.
Sep 2, 1929, 19 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa Idaho
Date of Burial: 9/1/29 19

20. Undertaker: Fred K. Robinson
Address: Nampa Ida

RECEIVED AUG 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67321

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 279

743

2. FULL NAME Johanna Sophia Myers

(a) Residence. No. .... St. ....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of James Henry Myers

6. DATE OF BIRTH (month, day and year) November 13 - 1856

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
72	7	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Morgan Co. Missouri

PARENTS

10. NAME OF FATHER John C. Bellmer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Ellen Gerkan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant J. A. Myers
(Address) Kooskia - Idaho.

15. Filed July 5 1929 J M Verbeckmoes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to July 2, 1929, that I last saw h[er] alive on July 1, 1929, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:
Cerebral Embolism -
.... (duration) .... yrs. .... mos. .... ds.
CONTRIBUTORY (Secondary) Chronic Endocarditis.
.... (duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? .... Date of ....
Was there an autopsy? ....
What test confirmed diagnosis? ....

(Signed) J M Verbeckmoes, M. D.
July 5, 1929 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: July Kooskia Cemetery — Date of Burial: July 6 1929
20. Undertaker: Leo Tremsey - Kooskia — Address ....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67222

PLACE OF DEATH
County of Idaho
City of Stites

Registration District No. 106
Primary Registration District No. 2184

Local Registrar's No. 278

(No.) 114
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cornelius Henry

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Indian	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 21 -

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Stites - Idaho
(State or country)

PARENTS

10. NAME OF FATHER John Henry
11. BIRTHPLACE OF FATHER (city or town) Washington
(State or Country)
12. MAIDEN NAME OF MOTHER Lynora James
13. BIRTHPLACE OF MOTHER (city or town) Stites - Idaho
(State or Country)

14. Informant Mrs Lynora Henry
(Address) Stites - Idaho.

15. Filed July 2, 19 29 J M Verbeck Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July - 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1929, to July 1, 1929
that I last saw h[illegible] alive on June 30, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Gastro enteritis - probably due to green fruit

(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J M Verbeck, M. D.
, 19 (Address) Rosska

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Stites - Idaho - Home Cemetery	July 3 1929
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67323

PLACE OF DEATH
County of Idaho
City of Riggins

Registration District No. 103
Primary Registration District No. 2181

Local Registrar's No. 32

(No. 182)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Francis Seyfried

(a) Residence. No. ..... St. .....
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
13			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ranchers Son.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER A. F. Seyfried.
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Bessie.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant J. R. Chamberlin.
(Address)

15. Filed Sept 1, 1929 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Accidental Drowning in Salmon River near Riggins Idaho
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) B Chipman M. D.
..., 19... (Address) Tranquille Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riggins Ida.	8-30-1929
20. Undertaker Neighbors of Riggins	Address

RECEIVED SEP 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67324

PLACE OF DEATH
County of Idaho
City of Grangeville.

Registration District No. 103
Primary Registration District No. 1001

Local Registrar's No. 31

(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Susan M Hall.

(a) Residence. No. Grangeville Id. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen Hall

6. DATE OF BIRTH (month, day and year) 8-18-1837

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	91	11	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bath Maine

PARENTS
10. NAME OF FATHER S. Haynes
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER ←
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Winfred Lauenberg
(Address) Grangeville Ida.

15. Filed 9-2-, 1929 V B Chapman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 6 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov., 1927, to Aug 6, 1929
that I last saw her alive on Aug 6 1929
and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Primary Syndrome

(Signed) V B Chapman, M. D.
8-30-, 1929 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida	8-8- 1929

20. Undertaker	Address
Limbaugh Mort. Co	Grangeville Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67325

PLACE OF DEATH
County of Idaho
City of Stites

Registration District No. 106
Primary Registration District No. 2184
Local Registrar's No. 280

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Johns ~~Rithel~~ Ritschel

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rosalie Ritschel

6. DATE OF BIRTH (month, day and year) May-20-1849

7. AGE Years 80 Months 2 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Emil Bart
(Address) Stites - Idaho

15. Filed Aug 5, 1929 J M Verbeekens Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3, 1929, to ~~Aug~~ July 31, 1929
that I last saw her alive on July 9, 1929
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial ~~Ph~~ Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J. M. Verbeekens M. D.
Aug 2, 1929 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker Geo Freeman | Address Kooskia Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67326

PLACE OF DEATH

County of Idaho

City of Kooskia

Registration District No. 106

Primary Registration District No. 2184

Local Registrar's No. 281

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eleanor Gonzales Anderson 101a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE Indian

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Anderson

6. DATE OF BIRTH (month, day and year)

7. AGE Years above 82 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Kaia

11. BIRTHPLACE OF FATHER (city or town) Idaho.
(State or Country)

12. MAIDEN NAME OF MOTHER ~~Not~~ Wat Wah tin my

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Corbett Lawyer
(Address) Lapwai, Idaho.

15. Filed Aug 5, 1929 J. M. Verbeekmoes. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to Aug 3, 1929

that I last saw her alive on Aug 2, 19..

and that death occurred, on the date stated above, at 2:00 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. M. Verbeekmoes, M. D.

Aug 5, 1929 (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal First Indian Church | Date of Burial Aug 5 1929

20. Undertaker Geo Tracey | Address

RECEIVED SEP 7 STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Kootenai. State Idaho. Registered No. 122
Township ____ or Village ____ or
City Worley. No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Susan Smatah 16N 67227

(a) Residence. No. Wellpinit. Washington. St., ____ Ward. Yes.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Indian.	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
Don't know age think near 100 years.			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Was advocate of Tribal customs.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Old Spokane
(State or country) Reservation.

PARENTS
10 NAME OF FATHER Don't know.
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER Don't know.
13 BIRTHPLACE OF MOTHER (city or town) Old Spokane Reservation.
(State or country)

14 Informant Susie Smisheel
(Address) Worley. Idaho.

15 Filed Aug 21, 1929 W. J. Sturges REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd. 29. 19

17 I HEREBY CERTIFY, That I attended deceased from I saw the Lady, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Old and Sickness.

(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (SECONDARY) General Failing.
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Don't know.
Did an operation precede death? No. Date of ____
Was there an autopsy? No.
What test confirmed diagnosis?

(Signed) J. J. Hennessey, M. D.
, 19 (Address) Worley. Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Worley Indian Cemetery.	July 4th 1929.
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

RECEIVED SEP 7 1929

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County of Kootenai State Idaho Registered No. 20
Township ____ or Village Worley or
City ____ No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

90 - 67328

2 FULL NAME Louise Finley Bonaparte,

(a) Residence. No. ____ St., ____ Ward. Yes. Flat Head.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female.	TRIBE: KOOTENAI Indian 3/4	Divorced

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph Bonaparte

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	73			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Midwife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Montana.
(State or country) Montana

PARENTS
10 NAME OF FATHER Pierre Finley
TRIBE: KOOTENAI
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Montana.
12 MAIDEN NAME OF MOTHER Susan Finley
TRIBE: KOOTENAI
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Montana.

14 Informant Records of Flathead Agency,
(Address) Dixon, Montana.

15 Filed 8/20, 19 H. J. Sturges
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 7th/1929

17 I HEREBY CERTIFY, That I attended deceased from
I never saw the Lady., 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at 9.30 A. m.
The CAUSE OF DEATH* was as follows:

No physician attending. Sick about 2 months. Informed heart trouble cause of death.

(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (SECONDARY) Heart trouble.
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) J. C. Harrington, M. D.
, 19 (Address) Worley, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Worley Indian Cemetery.	Feby 10 1929
20 UNDERTAKER	ADDRESS
None; buried by relatives.	

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—200 d
V. S. No. 98

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67229

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 126

(No. 880) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Bamon Sr.

(a) Residence No. Home Hospital St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
About	65			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dont

PARENTS

10. NAME OF FATHER Dont Know - Bamon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant C. Wendt
(Address) Coeur d'Alene. Ida.

15. Filed Aug 28, 1929 W. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. , 1929 to Aug 27, 1929
that I last saw him alive on Aug. 26, 1929
and that death occurred, on the date stated above, at 3:20 A. m.
The CAUSE OF DEATH* was as follows:
Myocarditis -
Chronic Interstitial Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. C. Dwyer M. D.
Aug 28, 1929 (Address) Coeur d'Alene, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Concordia MO	9— 1929
20. Undertaker	Address
Cassedy Funeral Home	Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67331

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 127
(No. 441)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Viola Paist
(a) Residence. No. 110 - Coeur d'Alene St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Divorced

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of W. C. Paist

6. DATE OF BIRTH (month, day and year) 1868 - 8 - 25

7. AGE	Years	Months	Days	If LESS than 1 day,
	60	11	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS:
10. NAME OF FATHER Jonny Brannan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Sora L Rodabah
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs. J. E. Bennett.
(Address)

15. Filed ..... 19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Aug 23, 1929, that I last saw her alive on Aug 22, 1929, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 18 mos.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of About July 1929
Was there an autopsy? No
What test confirmed diagnosis? Exploratory Operation

(Signed) J. E. Bennett, M. D.
Aug. 24, 1929 (Address) Coeur d'Alene, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C'dAlene	8-25-1929
20. Undertaker	Address
Cassedy Funeral Home	C'dAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 7 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

DO NOT WRITE IN THIS SPACE

State File No. 67332

Local Registrar's No. 129

(No. 162)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sophia Dochnoz

(a) Residence. No. Cougar Gulch St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1929 - 8 - 8

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or 0 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur d'Alene Idaho

PARENTS

10. NAME OF FATHER Christ Dochios

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Greece

12. MAIDEN NAME OF MOTHER Helen Deylea

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Greece

14. Informant C R Dochios

(Address)

15. Filed 8/21, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 8, 1929, to August 8, 1929

that I last saw her alive on August 8, 1929

and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Did not breathe, heart beat for 1 hr. 20 min.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Difficult Labor. Breech presentation

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harold T. Anderson M. D.

August 9, 1929 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cem. C'D'Alene — Date of Burial: 8-10 1929

20. Undertaker: Carsedy Funeral Home — Address: C'D'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67333

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 131

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Hjalmer Ekstromer

(a) Residence. No. Chicago, Ill. St. Chicago Ill.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About 56 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): unknown

PARENTS
10. NAME OF FATHER: John Ekstromer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Coroner's Office
(Address) Coeur d'Alene Idaho

15. Filed 8/21, 1921 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at not known m.
The CAUSE OF DEATH* was as follows:
Organic Disease of Heart
I found dead in auto at Arnolds Auto Camp Coeur d'Alene Idaho (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) R. B. Mooney Coroner M. D.
Aug 23, 1929 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane Cremation | Date of Burial: Sept 5 1929

20. Undertaker: R. B. Mooney | Address: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67334

PLACE OF DEATH
County of Kootenai
City of Coeur D' Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 132
(No.) 49
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sister Mary Camillus Hattan

(a) Residence. No. 9th and Coeur D' Alene St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 31, 1865

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	2	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sister Surerior, Academy
(b) General nature of industry, business, or establishment in which employed (or employer) Immaculate Heart of Mary
(c) Name of employer Coeur D' Alene

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Academy I. H. M.
(Address) Coeur d'Alene Idaho

15. Filed 8/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. 11, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan., 1927, to Aug. 12, 1929
that I last saw h[illegible] alive on July 10, 1929
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

Carcinomas of Lungs
7 Years
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 1927
Was there an autopsy? no
What test confirmed diagnosis? Microscopic

(Signed) John J. Cunningham, M. D.
Aug 12, 1929 (Address) Spokane

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Thomas Cemetery	aug 14 1929
20. Undertaker	Address
R. B. Mooney	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67235

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 130
(No. 1224)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucile Herron

(a) Residence. No. 1224 - 9th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Thomas Herron

6. DATE OF BIRTH (month, day and year) 1863 - 8 - 13

7. AGE	Years	Months	Days	If LESS than 1 day,
	66	0	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10. NAME OF FATHER — Olmstead
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant T. G. Herron
(Address) Coeur d'Alene Ida.

15. Filed 8/29, 1929 H. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 11 (Day) 1928 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to Aug 9, 1929 that I last saw her alive on Aug 9, 1929 and that death occurred, on the date stated above at m.

The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Harold J. Sturgis M. D.
8-12, 1929 (Address) C. d'A.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C'd'Alene	8-12 1929
20. Undertaker	Address
Cassedy Funeral Home	C'd'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67336

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 133

188 C

2. FULL NAME Jacob Ott
(a) Residence. No. 410 - 13 St N. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) 1901 - 8 - 1
7. AGE Years 28 Months 0 Days 15 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Will work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Blackwell Ltr. Co
9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10. NAME OF FATHER Geo. C. Ott
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Kate Litzenberger
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant Phillip C. Ott
(Address) Fire Station

15. Filed 8/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16, 1929, to Aug 16, 1929
that I last saw him alive on Aug 16, 1929
and that death occurred, on the date stated above, at 3:10 a. m.
The CAUSE OF DEATH* was as follows:
Shock
Crushing injury of chest, puncture of lung. Accidental injury
(duration) yrs. 1 1/2 mos. hours ds.
CONTRIBUTORY (Secondary) Automobile accident - Hayden Lake Road, Kootenai County
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Harold T. Anderson, M. D.
Aug. 16, 1929 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene — Date of Burial 8-18 1929
20. Undertaker Cassedy Funeral Home — Address C D Alene.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67337

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No.) 44
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 134

2. FULL NAME Anna L. Anderson
(a) Residence. No. 2012 Lakeside ave St. Dooley, Mont.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John P Anderson

6. DATE OF BIRTH (month, day and year) Oct 10, 1874

7. AGE Years 54 Months 10 Days 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS
10. NAME OF FATHER Chas Freiberg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden
12. MAIDEN NAME OF MOTHER Anna Volquist
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant John Peter Anderson
(Address) Dooley, Mont.

15. Filed 8/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Aug 3, 1929
that I last saw her alive on Aug 3rd, 1929
and that death occurred, on the date stated above, at 7 40 P m.
The CAUSE OF DEATH* was as follows:
Cancer of liver
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E H. Teed, M. D.
8-6-, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Olenty Wood Mont. Date of Burial 19

20. Undertaker R B Mooney Address Coeur d'Alene

RECEIVED SEP 7 1929

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Kootenai. State Idaho. Registered No. 121
Township ____ or Village Worley. Idaho. ____ or
City ____ No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

112 67238

2 FULL NAME Mary Louise.

(a) Residence. No. Worley. Idaho. St., ____ Ward. Yes.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female.	Spokane-Indian.	Divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Peone.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
70 or better.				

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Spokane County-,
(State or country) Peone Prarie.

PARENTS
10 NAME OF FATHER Pierre.
11 BIRTHPLACE OF FATHER (city or town) Spokane. Wash.
(State or country)
12 MAIDEN NAME OF MOTHER Mary Pouis Pierre*
13 BIRTHPLACE OF MOTHER (city or town) Spokane. Wash.
(State or country)

14 Informant Basil Peone
(Address) Worley. Idaho.

15 Filed 8/20, 1929 N. J. Sturges
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11th/ 1929 19

17 I HEREBY CERTIFY, That I attended deceased from
There was no Doctor called., 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

Complications of Diseases. "Flu

(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (SECONDARY) General brake down.
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? I don't know of any.

(Signed) J. J. Hennessee, M. D.
, 19 (Address) Worley. Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Worley Indian Cemetery.	July 12 19
20 UNDERTAKER H.G. Jaeger.	ADDRESS Plummer. Idah

11—3184

8—209 d
V. S. No. 98

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED SEP 7 1929

1 PLACE OF DEATH
County Kootenai. State Idaho. Registered No. 125
Township ..... or Village Worley. Idaho. or
City ..... No. ..... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

44-67339

2 FULL NAME Charley Cooper.
(a) Residence. No. ..... St., ... Ward. Yes.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male.
4 COLOR OR RACE Spokane - Indian.
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cathrine Cooper.

6 DATE OF BIRTH (month, day, and year) Think Born about 1846.

7 AGE 83. Years | Months | Days | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Spokane. Washington.

PARENTS
10 NAME OF FATHER Francis Lolowah.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Colville. Reservation Washington.
12 MAIDEN NAME OF MOTHER Mary An.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Little Spokane River.

14 Informant Peter Silas
(Address) Worley. Idaho.

15 Filed Aug 21, 1929 H. J. Sturges REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH 8.30.P

16 DATE OF DEATH (month, day, and year) Aug 5th/1929 19

17 I HEREBY CERTIFY, That I attended deceased from June 1st/, 1929, to Aug 5th/1929 19, that I last saw him alive on Aug 4th/19291, 19, and that death occurred, on the date stated above, at 8.30 m. A.M.
The CAUSE OF DEATH* was as follows:
Cancer of Liver.
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) General Failing in ~~Hea~~ -Health
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know.
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Personal Histo-ry and Close Observation.
(Signed) [signature], M. D.
, 19 (Address) Worley. Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Worley Indian Cemetery
DATE OF BURIAL 8-7 1929

20 UNDERTAKER [signature]
ADDRESS Plummer Ida.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—200 d
V. S. No. 98

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67341

PLACE OF DEATH
County of Kootenai
City of Rathdrum
Registration District No. 30
Primary Registration District No. 1650
Local Registrar's No. 135

(No. 74a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Smythe

(a) Residence. No. County Hospital St. Lane - Idaho
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widower

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Don't Know

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 80 years			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know Germany
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Maud Latimer
(Address) Rathdrum Ida

15. Filed 8/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1928, to Aug, 1929, that I last saw h[im] alive on Aug 14, 1929, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Coeur d'Alene, Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Harold J. Sturges, M. D.
Aug 15, 1929 (Address) C. D. A. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lane. Idaho	8-16 1929

20. Undertaker Cassedy Funeral Home Address C'Dalene Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67342

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Latah
City of Moscow

Registration District No. 101
Primary Registration District No. 1011
(No. Gritman Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 31

2. FULL NAME Calvin W. English

(a) Residence. No. ..... St. 183 Emida, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) April 28, 1924

7 AGE: Years 5 | Months 2 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Emida, Idaho

PARENTS
10 NAME OF FATHER: Allan M. English
11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.
12 MAIDEN NAME OF MOTHER: Lillian Dawson
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Idaho

14 Informant: A. M. English
(Address): Emida, Idaho

15 Filed Aug 2, 1929 W. H. Carithers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 5, 1929 (Month) (Day) 19.. (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19.., to ....., 19.., that I last saw h..... alive on ....., 19.., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Gunshot Wound of head — accidental
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) Chas. L. Gritman, M. D.
7/5, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Emida, Ida.
Date of Burial: 7/7/29 19

20. Undertaker: O. G. Meager
Address: St. Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67344

PLACE OF DEATH

County of Latah

City of Moscow (rural)

Registration District No. 61

Primary Registration District No. 2141

Local Registrar's No. 33

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martin Ulyssess Sten

(a) Residence. No. R.F.D. no. 1 St. 187
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Thelma Sten

6. DATE OF BIRTH (month, day and year): June 25, 1894

7. AGE: Years 35 | Months | Days 29 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Moscow (rural) Idaho

PARENTS

10. NAME OF FATHER: Ludwig Sten

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Louose Grundie

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Ludwig Sten
(Address): Moscow, Idaho

15. Filed July 25, 1929. W. H. Carithers, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 24/ 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24, 1929, to July 24, 1929, that I last saw him alive on July 24, 1929, and that death occurred, on the date stated above, at 5 30 m.

The CAUSE OF DEATH* was as follows:
Internal hemorrhage from Sup. mesenteric artery
Run over by binder
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Crushing blow to abdomen accidental
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) [signature], M. D.

7/27, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow | Date of Burial: 7/27/29 19

20. Undertaker: H. R. Short | Address: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67345

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No. Inland Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 34

2. FULL NAME Domminick Rodner

(a) Residence. No. 90 St.
(Usual place of abode)
Length of residence in city or town where death occurred. 27 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary L. Rodner

6. DATE OF BIRTH (month, day and year) Nov 7 1843

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	8	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoemaker (retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant W.E. Cahill
(Address) Moscow, Idaho

15. Filed July 30, 1929 W H Harrithers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 30, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7, 19 29 to July 30, 19 29
that I last saw him alive on July 30, 19 29
and that death occurred, on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
(1) Cardio-Vascular disease
(2) Pharyngeal Paralysis
(3) Substantia disease acute
Retention (duration) yrs. mos. 23 ds.
CONTRIBUTORY Involvt of bulbar centres
(Secondary)
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E L Nagel, M. D.
7/31/29, 19 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	8/2/29 19

20. Undertaker W. R. Short — Address Moscow

RECEIVED AUG 10 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67346

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Latah — Registration District No. 61
City of Moscow (rural) — Primary Registration District No. 1211
(No.) — Local Registrar's No. 32
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Irving Walter Paluthe

(a) Residence. No. 90 St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 15, 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		24	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Moscow, Idaho

PARENTS
10 NAME OF FATHER Richard H.W. Paluthe
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Lena L. Entel
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash.

14 Informant Richard Paluthe
(Address) Colton, Wash.

15 Filed July 9, 1929 W Haverstheers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 9, 1929 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1929, to July 9 1929, that I last saw him alive on July 8, 1929, and that death occurred, on the date stated above, at 6:00 A m.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Whooping cough
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Chas. L. Entel M. D.
7/10, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow	7/10/29 19
20. Undertaker F. P. Short	Address Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67347

PLACE OF DEATH
County of Latah
City of Genesee

Registration District No. 12
Primary Registration District No. 24-2

Local Registrar's No. 1

(No. 74a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME August Rach

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Amelia Rach

6. DATE OF BIRTH (month, day and year) March 31, 1848

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
81	3	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER John Rach
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Henry Rach
(Address) Moscow, Idaho

15. Filed July 24, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 23, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to July 23, 1929
that I last saw h~~im~~ alive on July 22, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.
Apoplexy
(duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY Arteriosclerosis.
(Secondary)
(duration) 20 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
7/23, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Genesee	7-25 1929
20. Undertaker F. R. Short	Address Moscow

RECEIVED AUG 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67348

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145

Local Registrar's No.

(No. 74a) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Morris Hadley.

(a) Residence. No. (Usual place of abode) St. (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 30 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	9		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Millwright
(b) General nature of industry, business, or establishment in which employed (or employer) Potlatch Lumber,
(c) Name of employer Co.

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER John

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana.

12. MAIDEN NAME OF MOTHER Margret Henry

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs Morris
(Address) Potlatch Ida.

15. Filed July 17th, 1929 Dr J.R. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 15th, 1929
that I last saw h[illegible] alive on July 15, 19
and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arterio - sclerosis.

(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J.R. Thompson, M. D.
July 17th, 1929 (Address) Portland

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Palouse Wash.	July 18 1929

20. Undertaker E.H. Ervin Palouse Wash. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 21 1929

PLACE OF DEATH

County of Latah

City of Potlatch

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 65

Primary Registration District No. 2145

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67349

Local Registrar's No. .....

2. FULL NAME Nelson Humiston 89

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) x x Not Known 1843

7. AGE Years 86 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wis

PARENTS

10. NAME OF FATHER S. B. Humiston

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wis

12. MAIDEN NAME OF MOTHER Elizeth Palmeteer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wis

14. Informant Geo Humiston
(Address) Potlatch Ida.

15. Filed July 22nd, 1929. Dr. Jno Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19....., to ✓, 19.....

that I last saw h ✓ alive on ✓, 19.....

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris
Died suddenly in bed -

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteria - Sclerosis

..... (duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jno Thompson, M. D.

July 22nd, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Potlatch Ida

Date of Burial July 25 1929

20. Undertaker E M Drum Palouse Wash.

RECEIVED AUG 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67350

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Klas Gustaf Anderson 129

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) x x Not Known. 1873

7. AGE Years 56 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer) Potlatch Lumber Co
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " " "
12. MAIDEN NAME OF MOTHER " " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " " "

14. Informant Chas Miller
(Address) Coville Ida.

15. Filed July 8th, 1929 Dr J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20th, 1929, to July 7th, 1929
that I last saw him alive on July 6th, 1929
and that death occurred, on the date stated above, at 3 A m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) 10 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Purpura Hemorrhagica
(duration) ..... yrs. ..... mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) Dr J. W. Thompson, M. D.
July 8th, 1929. (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Palouse Wash
Date of Burial July 20 1929

20. Undertaker J M Smith
Address Palouse Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 21 1929

Mail or Deliver This Certificate to Your Local Registrar. Not to the State Board of Health.

PLACE OF DEATH

County of Duluth

City or Town of

Registration Dist. No.

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information."]

~~WASHINGTON~~ STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 65

File No. 67351

Registered No. 2145

(No. , St.; Ward)

FULL NAME Johny Lowe

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

Personal and Statistical Particulars

3 Sex: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (Write the word): Married

6 Date of Birth: 5 (Month) 1 (Day) 1884 (Year)

7 Age: 40 yrs. 1 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8 Occupation
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9 Birthplace (State or country): Idaho

PARENTS

10 Name of Father: Samuel Lowe

11 Birthplace of Father (State or country): England

12 Maiden name of Mother: Anne Porter

13 Birthplace of Mother (State or country): Illinois

14 The above is true to the best of my knowledge

(Informant) Arthur Lowe

(Address) Farmington Wash

15 Filed July 24th 1929 J. W. Thompson Registrar.

Medical Certificate of Death

16 Date of Death: 7 (Month) 21 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 6 16 29, 191, to 7-21, 1929, that I last saw her alive on 7-21 1929, and that death occurred, on the date above, at 5 12 P m.

The CAUSE OF DEATH* was as follows:

Stomach

(Duration) yrs. 3 mos. ds.

Contributory (Secondary) Cancer Stomach

(Duration) 2 yrs. mos. ds.

(Signed) J. W. Lowe M. D.

July 22 1929 (Address) Farmington Wash

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 Length of Residence (For Hospitals, Institutions, Transients, or Recent Residents)
At Place of death yrs. mos. ds. In the State yrs mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence 5 miles S E from here

19 Place of Burial or Removal: Farmington Wash — Date of Burial: 7-23 1929

20 Undertaker: J M Thayer — Address: Farmington Wash.

RECEIVED AUG 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67352

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edgar Egra Darrow.

(a) Residence. No. 129 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 5 1852

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER L Darrow.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER Laura Oneil.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant Mrs R A Rice
(Address) Potlatch Ida.

15. Filed July 30th, 1929 J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26th, 1929, to July 28th, 1929
that I last saw him alive on July 28, 19
and that death occurred, on the date stated above, at 1155 a m.
The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) - Gall Stone Colic
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J. W. Thompson, M. D.
July 30th, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Garfield Wash	July 31 1929

20. Undertaker Address
E M Irwin Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67353

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Floyd David Haskins

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
17	3	30	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Planer
(b) General nature of industry, business, or establishment in which employed (or employer) Saw Mill
(c) Name of employer Potlatch Lumber Co

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER H. M. Haskins

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Jamie Crosby

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant H. M. Haskins
(Address) Potlatch Idaho

15. Filed Aug 1st, 1929 J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8th, 1929, to July 31st, 1929
that I last saw him alive on July 31st, 1929
and that death occurred, on the date stated above, at 8-30 P m.

The CAUSE OF DEATH* was as follows:
Peritonitis result of ruptured appendix.
(duration) ..... yrs. ..... mos. 24 ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes No Date of July 8
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) F C Gibson, M. D.
Aug 1st, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Potlatch Idaho	Aug 4 1929

20. Undertaker E. M. Invin Address Palouse Wash

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67354

PLACE OF DEATH

County of Latah

City of Troy

Registration District No.

Primary Registration District No.

Local Registrar's No. 1809

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clifford E. Sundquist (Known as Clifford Elton Harris) (Usual full name)

(a) Residence. No. (Usual place of abode) St. (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 20 1912

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
17	0	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Inland Forest Products Inc.

9. BIRTHPLACE (city or town) (State or country) Winchester Ida

PARENTS

10. NAME OF FATHER Roy Harris

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Mrs Mina Sundquist

(Address) Troy Idaho

15. Filed Aug 31 19 29 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 19, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at about 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Crushed by falling tree
Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. R. Hart Coroner M. D.

8/20, 19 29 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow Ida	Aug 25 1929

20. Undertaker	Address
John J. Pickerd	Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 7 1929

PLACE OF DEATH

County of Latah

City of Troy.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67355

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME John August Pearson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 31 1870

7. AGE Years 59 Months 2 Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden.

PARENTS

10. NAME OF FATHER Per Pearson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden.

12. MAIDEN NAME OF MOTHER Marit Johannson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs John Kalin

(Address) Troy Idaho.

15. Filed Aug 31, 1929 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 7 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from on Aug. 7, 1929 only. 19

that I last saw him alive on Aug. 7, 1929

and that death occurred, on the date stated above, at 7:00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

About (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? X Ray

(Signed) Harry Emhouse M. D.

Aug. 8, 1929 (Address) Moscow Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Dry creek cem

Date of Burial Aug 11 1929

20. Undertaker John J. Pickerd

Address Troy Ida

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67356

PLACE OF DEATH

County of Latah
City of Troy
Registration District No. 64
Primary Registration District No. 2144
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ida Carrie Steiger
(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	School girl

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
11	4	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montana

PARENTS

10. NAME OF FATHER Henry Steiger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Romnona
12. MAIDEN NAME OF MOTHER Carrie Truck
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Henry Steiger
(Address) Deary Ida

15. Filed Aug 31, 1929 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Aug 17, 1929
that I last saw h alive on Aug 17, 1929
and that death occurred, on the date stated above, at 9 A. m.
The CAUSE OF DEATH* was as follows:
Acute suppuration of hip joint.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) Chas A. Meyer, M. D.
Aug 18, 1929 (Address) Troy Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Texas Ridge cem	Aug 18 1929
20. Undertaker	Address
John J Pickard	Troy Ida

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67357

PLACE OF DEATH
County of Latah
City of Troy

Registration District No. 64
Primary Registration District No. 2144
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clair Atwood

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

1889

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 6 1911

7. AGE	Years	Months	Days	If LESS than 1 day,
	18	1	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Al School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Inland Forest Products Inc.

9. BIRTHPLACE (city or town) (State or country) Sales Ida.

PARENTS

10. NAME OF FATHER E. E. Atwood
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Yuba Michigan
12. MAIDEN NAME OF MOTHER Julia Mayfolland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Saginaw Missouri

14. Informant E. E. Atwood
(Address) Troy Ida.

15. Filed aug 31, 1929 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 19, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at about 4:30 P. m.

The CAUSE OF DEATH* was as follows:
crushed by falling tree
Accidental
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H. R. Stott Coroner M. D.
8/20, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow Ida	aug 25 1929
20. Undertaker	Address
John J. Pickard	Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67358

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011

Local Registrar's No. 36

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Franklin Cox. 90

(a) Residence. No. 309 S. Polk St. (Usual place of abode)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Cox

6. DATE OF BIRTH (month, day and year) Feb. 23 1842

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	# 5	# 11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Joseph Cox
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Cyntha Holler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Ina Adair
(Address) Potlatch Idaho

15. Filed Aug 5, 1929 W. H. Carruthers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to Aug 4, 1929, that I last saw h[illegible] alive on Aug 4 1929 and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:
Cardio-renal disease

(duration) None yrs. mos. ds.
CONTRIBUTORY (Secondary) Edema
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

Aug 5, 1929 (Signed) C. H. Rigby, M. D. (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Troy Ida	8/7 1929
20. Undertaker F. R. Short	Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67359

PLACE OF DEATH

County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 37

90

2. FULL NAME WILLIAM RODRICK TOMER

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug. 15, 1856

7. AGE: 72 Years — Months: 11 Days: 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nevada Co. California.

PARENTS

10. NAME OF FATHER: GEORGE W TOMER
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Elizabeth Montgomery
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: George M Tomer
(Address): Moscow Idaho

15. Filed Aug 10, 1929. W H Carithers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to Aug 10, 1929
that I last saw him alive on Aug 10, 1929
and that death occurred, on the date stated above, at Aug 10 11 m.
The CAUSE OF DEATH* was as follows:
Acute Heart Disease.
Mitral Insufficiency.
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute inflammatory Rheumatism
(duration) 3½ yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical.
(Signed) C. T. Gretman, M. D.
8/12, 1929 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow Ida — Date of Burial: 8/12 1929

20. Undertaker: H. R. Short — Address: Moscow

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67360

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No. 49)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 38

2. FULL NAME JAMES PETER HOWARD

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nettie Howard

6. DATE OF BIRTH (month, day and year) Oct. 9, 1844.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	10	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Old civalwar veteran
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rochester New York

PARENTS

10. NAME OF FATHER James Howard

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Nettie Howard
(Address) Moscow Idaho

15. Filed Aug 13, 1929 W. H. Garithers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 13 (Day) 1929 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1929, to Aug. 13, 1929.
that I last saw h[illegible] alive on Aug. 13, 1929.
and that death occurred, on the date stated above, at 11:45 a.m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris

about (duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Appoplexy.
(duration) 7 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis? Clinical
(Signed) J. Harry Einhorn M. D.
Aug. 14, 1929 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	Aug 15 1929

20. Undertaker	Address
H. R. Short	Moscow, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67361

PLACE OF DEATH
County of Latah
City of ##### Moscow
Registration District No. 61
Primary Registration District No. 1011
(No. Inland Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 39

2. FULL NAME Daniel Tolfson

(a) Residence. No. 101a St. Troy Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 27, 1860

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	68	8	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Holmdchll Sweden

PARENTS

10. NAME OF FATHER: Tolfson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Danielson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: John Tolfson
(Address): Troy, Idaho

15. Filed Aug 18, 1929 W. H. Carruthers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 17, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1929, to Aug 17, 1929, that I last saw h im alive on Aug 17, 1929, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH was as follows:
Lobar Pneumonia
(duration) yrs. 4 ds.
CONTRIBUTORY (Secondary) (2) Cardiac failure
(duration) yrs. mos. hrs. ds.

18. Where was disease contracted if not at place of death? Troy Ida
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Physical

(Signed) C. J. Magee, M. D.
8/19, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dry Creek Cemetery	8/20/29 19

20. Undertaker: F. R. Short
Address: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 11 1929

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67362

PLACE OF DEATH

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

Local Registrar's No. 40

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kathryn Hatley

(a) Residence. No. ..... St. 74a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: N.P. Hatley

6. DATE OF BIRTH (month, day and year): Dec. 5, 1859

7. AGE: Years 69, Months 8, Days 12. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Salt Lake City Utah

PARENTS

10. NAME OF FATHER: W.R. Holden

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ten.

12. MAIDEN NAME OF MOTHER: Jane R. Gustin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: Myrtle Hatley
(Address): Moscow, Idaho

15. Filed Aug 18, 1929 W.H. Carithers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY That I attended deceased from I only saw her P.M. Aug 17, 1929 to ..... that I last saw h..... alive on in Feby 1929 and that death occurred, on the date stated above, at 10 45 p m.

The CAUSE OF DEATH* was as follows: Hemiplegia c̄ Cerebral Softening

..... (duration) 1½ yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Cardiac

..... (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? Seattle Wn

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) [signature], M. D.

8/19, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow

Date of Burial: 8/20/29 19

20. Undertaker: H. R. Short

Address: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1929

PLACE OF DEATH

County of Latah

City of Moscow

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

(No. Gritman Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67363

Local Registrar's No. 42

1000

2. FULL NAME Virgil Rafiel Ayler

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Dec. 17, 1923

7. AGE: Years 5, Months 8, Days 13. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Spokane, Wash.

PARENTS

10. NAME OF FATHER: Edgar James Ayler

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Grand Rapid N. Dak.

12. MAIDEN NAME OF MOTHER: Lela Branch

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dix Ill.

14. Informant: Edgar James Ayler

(Address): Moscow, Idaho

15. Filed Aug 31, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August ~~24~~ 30 ~~29~~
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 19, 1929 to Aug 24, 1929 that I last saw him alive on Aug. ~~19~~ ~~24~~ 30, 1929 and that death occurred, on the date stated above, at 11 39 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): La Grippe

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

Sept. 2, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow

Date of Burial: 9/2/29 19

20. Undertaker: H. R. Short

Address: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1929

[redacted]

DO NOT WRITE IN THIS SPACE

State File No. 67364

PLACE OF DEATH

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 2141

Local Registrar's No. 41

(No. Latah County Home)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Brown

74a

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Not known

6. DATE OF BIRTH (month, day and year) Not known

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Common Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not known

PARENTS

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Records at County Home

(Address)

15. Filed Aug 28, 1929 W. T. Hearithers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 28, 1929 (Month) (Day)

17. I HEREBY CERTIFY, That I attended deceased from June, 1929, to Aug 28

that I last saw him alive on Aug 27

and that death occurred, on the date stated above, at 1

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. .....

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. .....

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Opinion

(Signed) J. W. Stevens

8/28 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from CAUSES, state (1) MEANS AND NATURE OF INJURY whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	8/28 1929

20. Undertaker	Address
H. R. Short	Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67365

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 4
Primary Registration District No. 2116
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Adie Ermin

(a) Residence. No. Soda Springs St. Ida
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years: about 40 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): American

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Wm C Hoobler
(Address): Salmon Ida.

15. Filed Aug 17, 1929. Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 30th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1929, to June 30, 1929
that I last saw him alive on June 30, 1929
and that death occurred, on the date stated above, at 9-P— m.
The CAUSE OF DEATH* was as follows:

Myocarditis

about 7 years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Wyoming
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hamm, M. D.
July 15, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	July 1st 1929
20. Undertaker: Wm C Hoobler	Address: Salmon Ida.

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67366

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 4
Primary Registration District No. 2116
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nellie E Clark

(a) Residence. No. Salmon Idaho St. 1000
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years: 86 — Months: 3 — Days: 11 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boston Mass.

PARENTS

10. NAME OF FATHER: Thomas Kelley.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: Mrs Peter McKenney
(Address): Salmon, Ida.

15. Filed Aug 7, 1929. Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 17th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from June 16, 1929, to July 17, 1929
that I last saw her alive on , 19
and that death occurred, on the date stated above, at 10- A- m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) General debility
senile (duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Chas F. Hamm, M. D.
July 18, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery — Date of Burial: 7-12" 1929
20. Undertaker: J. W. C. Jacobs — Address: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67367

PLACE OF DEATH
RECEIVED AUG 22 1929
County of Lemhi
City of Salmon
Registration District No. 41
Primary Registration District No. 2116
Local Registrar's No.
(No. 129)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Robinson

(a) Residence. No. Gilmore Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not known

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	63			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Tenarty Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant Wm C Doebler
(Address) Salmon Ida

15. Filed Aug 17, 1929. Chas Dillaway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 18, 1929, that I last saw h[illegible] alive on July 18, 1929, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart trouble

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Salmon Ida
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) F. S. Wright, M. D.
July 19, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	7/19" 1929
20. Undertaker	Address
Wm C Doebler	Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED AUG 22 1929

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67368

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Fred Pratt

(a) Residence. No. Salmon Idaho St. 101a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) —

7. AGE: Years 63 | Months 7 | Days 5 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: cattleman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Prophetown Illinois

PARENTS

10. NAME OF FATHER: Thurston D Pratt
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Catherine Kaier
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Effie Pratt Sullivan
(Address) 507 W Lincoln Way Kearney Nebr

15. Filed Aug 17, 1929 Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21st (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19, 1929 to June 21, 1929
that I last saw him alive on June 21, 1929
and that death occurred, on the date stated above, at 6-30 P m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) J. Stratton, M. D.
June 24, 1929 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery | Date of Burial: June-24 1929

20. Undertaker: Jno C Daehler | Address: Salmon Ida

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 2 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lewis

City of Nezperce Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 47

Primary Registration District No.

(No. ....., ... St.)

File No. 67369

Registered No. 144

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Wheeler Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Child

6. DATE OF BIRTH. October 22 1929 (Month) (Day) (Year)

7. AGE 7 Yrs. 9 Mos. 11 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Child

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Nezperce Idaho

10. NAME OF FATHER Bernise Keltner Thomas

11. BIRTHPLACE OF FATHER (State or Country) Nezperce Idaho

12. MAIDEN NAME OF MOTHER Florence Higbee

13. BIRTHPLACE OF MOTHER (State or Country) Tekoa Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bernise Thomas

(Address) Nezperce, Idaho

15. Filed Aug 30 1929

Albert Huff
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 13 1929 (Month) (Day) (Year)

57 Dunlap

17. I HEREBY CERTIFY, That I attended deceased from July 1927, to July 13 1929, that I last saw him alive on July 13 1929, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) R E Dwelle M. D.

8/7 1929 (Address) Sequent Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Nezperce Cemetery

DATE OF BURIAL July 15 1929

20. UNDERTAKER Albert Huff

ADDRESS Nezperce Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SGRS. 24653

RECEIVED SEP 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67370

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 50
Primary Registration District No. 2179
Local Registrar's No. 17
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Wayne
(a) Residence. No. ..... St. 161a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mae
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): —
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Aug 24 1929
7. AGE: Years | Months | Days | If LESS than 1 day, 2½ hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Winchester Ida

PARENTS
10. NAME OF FATHER: W. W. Wayne
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Miriam Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: W. W. Wayne
(Address): Craigmont Ida
15. Filed 9/1, 1929 R. E. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug - 24 - 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 25, 1929, to Aug 24, 1929
that I last saw him alive on Aug - 24 - 1929
and that death occurred, on the date stated above, at 10:45 P. m.
The CAUSE OF DEATH* was as follows:
Premature Infant
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John F. Gist, M. D.
Aug 25, 1929 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Craigmont Ida | Date of Burial: Aug 25 - 1929
20. Undertaker: Clyde Clevis | Address: Craigmont Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67371

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 50
Primary Registration District No. 2129
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 16

2. FULL NAME Winfred Wayne

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

161a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 24 1929

7. AGE Years Months Days If LESS than 1 day, 14 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winchester Ida

PARENTS

10. NAME OF FATHER W. W. Wayne
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Miriam Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant W. W. Wayne
(Address) Craigmont, Ida

15. Filed 9/1, 1929 R. C. Dunch Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug / 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug/24, 1929, to Aug/25, 1929
that I last saw him alive on Aug 25, 1929
and that death occurred, on the date stated above, at 11 30 a. m.
The CAUSE OF DEATH* was as follows:
Premature Infant
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John F. Gist M. D.
Aug 25, 1929 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Craigmont Ida
Date of Burial Aug 25 1929

20. Undertaker Clyde Colvin
Address Craigmont Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 2 1929

PLACE OF DEATH

County of Lewis

City of Winchester

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67372

Registration District No. 60

Primary Registration District No. 2129

Local Registrar's No. 14

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel D. Johnson

(a) Residence. No. ..... St. 49

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 4/13/1872

7. AGE: 57 Years, 4 Months, 2 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work R.R. Man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Craig Mountain Lbr Co.

9. BIRTHPLACE (city or town) (State or country) Pollock Mo.

PARENTS

10. NAME OF FATHER Wm Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pollock Mo

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Carl Johnson

(Address) Portland Oregon.

15. Filed 8/16, 1929. F E Dunn Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug - 15 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1929 to Aug 15, 1929

that I last saw him alive on Aug 15, 1929

and that death occurred, on the date stated above, at 7 45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Inferior Maxillary & Mediastinal Glands.

..... (duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John F. Gist M. D.

Aug 15, 1929 (Address) Winchester Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho — Date of Burial: 8/16 1929.

20. Undertaker: Brown-Towne Co — Address: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67373

PLACE OF DEATH
County of Lewis
City of Mohler

Registration District No. 6P
Primary Registration District No. 2129
Local Registrar's No. 13

(No. 74a) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret C Smith

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. M. Smith

6. DATE OF BIRTH (month, day and year) Aug 14 1862

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	11	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER Peter Hart

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Catherine Kyle

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pennsylvania

14. Informant J M Smith
(Address) Mohler.

15. Filed 8/17, 1929 R E Daniels Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19 17, to Aug 7, 19 29
that I last saw h[illegible] alive on Aug 6, 19 29
and that death occurred, on the date stated above, at 1.30 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.
(7 attacks)
(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Interstit. Nephritis
Angina Pectoris
(duration) 12 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Wassermann

(Signed) R E Daniels, M. D.
8/14, 1929 (Address) Graigmont Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nez Perce Idaho	8-8-1929
20. Undertaker	Address
Star Hdwe & Impl Co	Craigmont Ida

RECEIVED SEP 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67374

PLACE OF DEATH
County of Bingham
City of Aberdeen

Registration District No. 116
Primary Registration District No. 2155
Local Registrar's No. 27
(No. 88a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruby Bernice Lehrman
(a) Residence. No. ——— St. Aberdeen Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word):
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ———
6. DATE OF BIRTH (month, day and year) May 1 1919
7. AGE Years 10 Months 3 Days 25 If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer) ———
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Dubois Idaho

PARENTS
10. NAME OF FATHER Henry H Lehrman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Theresa Wiebe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Henry H. Lehrman
(Address)
15. Filed Aug 27, 1929 M C Mackinnon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 25 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan, 1928, to Aug 27, 1929
that I last saw her alive on Aug 26, 1929
and that death occurred, on the date stated above, at 6 A m.
The CAUSE OF DEATH* was as follows:
Endocarditis
(duration) 4 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Chronic nephritis
(duration) 1 yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? X-Ray
(Signed) M. C. Mackinnon M. D.
Aug 27, 1929 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal — Homestead Cemetery Aberdeen Ida
Date of Burial 8/28 1929
20. Undertaker A W Davis American Falls Ida
Address

TION is very important. See instruction on back of certificate.

FORM V. S. No. 1—25 M.—1-19.

RECEIVED SEP 12 1929

CERTIFICATE OF DEATH

K

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

File No. 42

County of Minidoka

City of Paul (No. ....., ... St.)

Registered No. 27975

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Schiedt 149

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Fem	White	Married

6. DATE OF BIRTH: June (Month) 10 (Day) 1892 (Year)

7. AGE: 36 Yrs. 11 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: George Arbes

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Mary K Brown

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A John Schiedt

(Address) Paul Idaho

15.

Filed ..... 19 .....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1929, to May 13 1929, that I last saw h.er alive on May 13 - 1929, and that death occurred on the date stated above, at 8 P. M.?

The CAUSE OF DEATH* was as follows:

Died in confinement probably from ah embolus

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Kennagy M. D.

8/24 1929 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Paul Cemetery	May 15 1929
20. UNDERTAKER	ADDRESS
W. A. Goodman	Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

J.B.K.

RECEIVED SEP 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

File No. 4

Registered No. 67376

County of Mandoka

City of Rupert

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eli Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
m	white	Single

6. DATE OF BIRTH: December 12 1971 (Month) (Day) (Year)

7. AGE: 57 Yrs. [redacted] Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John a. Miller

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sarah Gentle

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James N. Miller

(Address) Rupert Idaho

15.

Filed ..... 19 .....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 14 1929 (Month) (Day) (Year)

74A

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Died suddenly from cerebral hemorrhage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Kennedy M. D.

6/24 1929 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	June 16 1929

20. UNDERTAKER	ADDRESS
Rodney Goodman	Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 12 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19 TT
Primary Registration District No. 2025
File No. 4
Registered No. 67378

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Octavia Christman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 17 (Day) 1865 (Year)

7. AGE: 64 Yrs. 1 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: [redacted] Hoffman

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Rose

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A P Christman
(Address) Rupert Idaho

15.
Filed ..... 19 .....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 14a 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Apoplexy ?
Died Suddenly
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F H Kenagy M. D.
8-29-1929 (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Apr 17 1929

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 12 1929

CERTIFICATE OF DEATH

f

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

County of

Primary Registration District No. 2015

File No. 41

City of

(No. , St.)

Registered No. 67979

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Everard W. Benjamin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Feb (Month) 25 (Day) 1851 (Year)

7. AGE: 78 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York C

10. NAME OF FATHER: William Benjamin

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Sarah Marie

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emily Benjamin

(Address) Trinidad Colorado

15.

Filed 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1929, to June 26 1929, that I last saw h[illegible] alive on June 25 1929, and that death occurred on the date stated above, at 2 00 P.M.

The CAUSE OF DEATH* was as follows:

Accident - caused by fall from sidewalk to street resulting in bruises on R leg + foot

(Duration) Yrs. 11 mos. ds.

Contributory (Secondary) Arteria Sclerosis

(Duration) about 10 yrs. mos. ds.

(Signed) Leland Benjamin M. D.

19 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Agate Colorado — DATE OF BURIAL: June 29 1929

20. UNDERTAKER: W. C. Goodenough — ADDRESS: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 12 1929

CERTIFICATE OF DEATH

F

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

File No. 40

Registered No. 67380

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: May (Month) 23 (Day) 1929 (Year)

7. AGE: ..... Yrs. 6 Mos. ..... ds.

IF LESS than 1 day how many 1 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Thompson

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Nancy E Christensen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Thompson

(Address) Rupert R 4

15.

Filed ..... 19 .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

162

16. DATE OF DEATH: May (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1929, to May 23 1929, that I last saw him alive on May 23 1929, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Anemia (Blue baby) - Failure of closure of Foramen ovale

..... (Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leland Fregier M. D.

..... 19 ..... (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery

DATE OF BURIAL: May 24 19 [illegible]

20. UNDERTAKER: W. G. Goodman

ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

File No. 39

Registered No. 67381

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alfred E Ross

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 6 (Day) 1860 (Year)

7. AGE: 68 Yrs. 5 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Johnathan Ross

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Elizabeth Kinnie

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Etna Roberts

(Address) New York

15.

Filed ..... 19 .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1929, to June 4 1929, that I last saw him alive on June 3 1929, and that death occurred on the date stated above, at 2:30 a M.

The CAUSE OF DEATH* was as follows:

Rocky Mountain Spotted Fever

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leland Frazier M. D.

..... 19 ..... (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Heyburn Cemetery

DATE OF BURIAL: June 6 1929

20. UNDERTAKER: W. A. Goodman

ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Minidoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19
Primary Registration District No. 2015
(No. ..... St.)

File No. 98
Registered No. 67382
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ulysses G. Patrick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Never Married, Widowed, Divorced)

6. DATE OF BIRTH: Nov (Month) 27 (Day) 1868 (Year)

7. AGE: 60 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Samuel J Patrick

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Samantha Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth Ferguson
(Address) Elsina Washington

15.
Filed ..... 19 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from I saw this man to about half hours 19 ..., that I last saw him alive on the twenty 19 ..., and that death occurred on the date stated above, at 10 A.M. Mr. Patrick died of the
The CAUSE OF DEATH* was as follows:
Arteria Sclerosis

About 10 (Duration) Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pernicious Anemia
(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) Leeson Ferguson M. D.
19 ..... (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: June 25 1929

20. UNDERTAKER: W. J. Goodman — ADDRESS: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

F

DO NOT WRITE IN THIS SPACE
State File No. 67383

PLACE OF DEATH
County of Minidoka
City of Acequia
Registration District No. 19
Primary Registration District No. 2015
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Petter L Ellsworth

(a) Residence. No. St. 101 B
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov 16 1849

7 AGE: Years 79 | Months 9 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: Farmer
(a) Trade, profession, or particular kind of work
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ont Canada

PARENTS

10 NAME OF FATHER Joe Ellsworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Sarah M Levens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Catherine Ellsworth
(Address) Acequia

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August 20th 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1928, to Aug 20, 1929, that I last saw him alive on Aug 20, 1929, and that death occurred, on the date stated above, at 10:40 m.

The CAUSE OF DEATH* was as follows:
Aortic Insufficiency
About (duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia, Chronic bilateral Nephritis
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Leland Francis, M. D.
, 19 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cemetry
Date of Burial: Aug 22 19 29

20 Undertaker: W. A. Gardner
Address: Rupert

RECEIVED SEP 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67384

PLACE OF DEATH

County of Minidoka

City of Rupert

CERTIFICATE OF DEATH

Registration District No. 1

Primary Registration District No. 2015

Local Registrar's No. 36

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Grant B. Bateman

187

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: 11 Years | Months 1 | Days 0 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10 NAME OF FATHER: O J Bateman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Utah

12 MAIDEN NAME OF MOTHER: Emma E Bringhurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Utah

14 Informant: Mrs Emma E Bateman

(Address) Rupert Idaho

15 Filed 8-29, 1929 E H Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August (Month) 8 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1929, to Aug 8, 1929, that I last saw him alive on Aug 8, 1929, and that death occurred, on the date stated above, at 8:10 a.m.

The CAUSE OF DEATH* was as follows:

Accidental cutting off of thigh by mowing machine with excessive bleeding.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Complete removal

Was there an autopsy? no (of leg)

What test confirmed diagnosis? .....

(Signed) E H Elmore M. D.

Aug 29, 1929 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cemetery

Date of Burial: 19

20. Undertaker: W. A. Goodman

Address: Rupert Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 12 1929

CERTIFICATE OF DEATH

E

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Minidoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19
Primary Registration District No. 2015
(No. ..... St.)

File No. 67385
Registered No. 93

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agatha E Titus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: May (Month) 11 (Day) 1851 (Year)

7. AGE: 77 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: G. W. Crook

11. BIRTHPLACE OF FATHER (State or Country): United States

12. MAIDEN NAME OF MOTHER: Lucetta Moberly

13. BIRTHPLACE OF MOTHER (State or Country): United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Grace Carlson
(Address) Rupert. Ida.

15. Filed 8-24 1929 E B Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1928 to April 19 1929, that I last saw her alive on April 19 1929, and that death occurred on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:
Diabetes
Arteriosclerosis
(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E B Elmore M. D.
8-27 1929 (Address) Rupert. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL 19 .....

20. UNDERTAKER: W. G. Gardner — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED SEP 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

E

DO NOT WRITE IN THIS SPACE
State File No. 67386

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Minidoka
City of Rupert
Registration District No. 19
Primary Registration District No. 2015
(No.)
Local Registrar's No. 24

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Charles A. Lance

(a) Residence. No. 74A St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb 1 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	81	6	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Elmer Morgan
(Address) Rupert Idaho

15 Filed 8-24, 1929 Alb E Lmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 19 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1929, to Aug 19, 1929, that I last saw him alive on Aug 9, 1929, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:
Apoplexy, Chronic Heart disease
(duration) ... yrs. 4 mos. ... ds.
CONTRIBUTORY (Secondary) Chronic Heart disease
(duration) 10 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Alb E Lmore M. D.
..., 19... (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Heyburn Cem	Aug 28 1929
20. Undertaker	Address
Rodney Goodman	Rupert Ida

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

File No. 67387

Registered No. 93

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 12 (Day) 1860 (Year)

7. AGE: 69 Yrs. 3 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stockman

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: William Johnson

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Thorp

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Pauline Johnson

(Address) Rupert Idaho

15. Filed 8-24 1929 E H Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1929, to April 15 1929 that I last saw him alive on April 15 1929, and that death occurred on the date stated above, at 3 40 A M.

The CAUSE OF DEATH* was as follows:

Tick or Rocky mountain Spotted Fever

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E H Elmore M. D.

8-27 1929 (Address) Rupert, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Gem

DATE OF BURIAL: Apr 18 1929

20. UNDERTAKER: W. J. Goodman

ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 12 1929

CERTIFICATE OF DEATH

E

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

File No. 67388

County of Minidoka

City of Rupert (No. ....., ... St.)

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander McKenzie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
m	white	Married

6. DATE OF BIRTH: April (Month) 4 (Day) 1857 (Year)

7. AGE: 72 Yrs. 7 Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Simon McKenzie

11. BIRTHPLACE OF FATHER (State or Country): Scotland.

12. MAIDEN NAME OF MOTHER: Mary Ashen.

13. BIRTHPLACE OF MOTHER (State or Country): Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rose A Tabb
(Address) Rupert Idaho

15. Filed 8-24 1929 Ed E Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1929, to June 10 1929, that I last saw him alive on " 10 1929, and that death occurred on the date stated above, at 4:40 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis,

Chronic valvular disease

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ed E Elmore M. D.

8-27 1929 (Address) Rupert Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	June 14 1929
20. UNDERTAKER	ADDRESS
Rodney Goodman	Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67389

County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
Local Registrar's No. 31

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Herman Leon Johnson 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 28 1917

7. AGE Years 11 Months 10 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Rupert
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Herman A Johnson
11. BIRTHPLACE OF FATHER (city or town) Brigham City
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Mae M Martindale
13. BIRTHPLACE OF MOTHER (city or town) Brigham City
(State or Country) Utah

14. Informant H.A.Johnson
(Address) Rupert Idaho.

15. Filed 8-26, 1929 E H Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 25 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Aug., 1927, to Aug 26, 1929
that I last saw him alive on 23, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH was as follows:
Cardiac Dilatation & chronic valvular disease
(duration) 6 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Rheumatism
(duration) ..... yrs. 3 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) E H Elmore M. D.
Aug 27, 1929 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rupert Ida
Date of Burial Aug. 26 1929

20. Undertaker D.E.Johnson
Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67390

PLACE OF DEATH

County of Minidoka

City of Rupert

Registration District No. 19

Primary Registration District No. 9015

Local Registrar's No. 30

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Roscoe Orton

107

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Aug. 21, 1921

6. DATE OF BIRTH (month, day and year)

7. AGE Years 7 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chesterfield Ida.

PARENTS

10. NAME OF FATHER John Barnett Orton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nort Ogden Weber Co Ut

12. MAIDEN NAME OF MOTHER Ethel Loveland

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant J. B. Orton
(Address) Rupert Idaho

15. Filed 8-22, 1929 Ett Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1928, to Aug 16, 1929 that I last saw h..... alive on Aug 15, 1922 and that death occurred, on the date stated above, at 8:55 P m.

The CAUSE OF DEATH* was as follows:
Fibrous condition of upper lobe R. Lung - with bronchitis down + abscess formation
..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Aspiration Pneumonia
R Lung (duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Leland Frazier, M. D.

....., 19..... (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rupert Ida. Date of Burial Aug. 1929

20. Undertaker D. E. Johnson Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67391

PLACE OF DEATH
County of Minedoka
City of Heyburn
Registration District No. 19
Primary Registration District No. 2015
Local Registrar's No. 29
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Shirley May Olson

(a) Residence. No. 177 St. ....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 10 1928

7. AGE	Years	Months	Days	If LESS than 1 day,
		9	26	....hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer ....

9. BIRTHPLACE (city or town) Heyburn Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Leo Olson

11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Vera Card

13. BIRTHPLACE OF MOTHER (city or town) Utah.
(State or Country)

14. Informant Leo Olson
(Address) Heyburn Idaho.

15. Filed 8-9, 1929 E. W. Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6, 1929, to Aug 6, 1929
that I last saw her alive on Aug 6 9.45 1929
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows:

Kerosene Poisoning, Taken accidentally

(duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) ....
(duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? .... Date of ....
Was there an autopsy? ....
What test confirmed diagnosis? ....

(Signed) E. W. Elmore M. D.
8-9, 1929 (Address) Rupert, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Heyburn Ida	Aug. 8 1929
20. Undertaker D. E. Johnson	Address Burley

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67392

PLACE OF DEATH
County of Nez Perce
City of Gifford R.F.D. 1

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No. 29

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Abraham Siegel Walker

(a) Residence. No. 33 St. Toppenish, Wash
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Sadie Goff Walker

6. DATE OF BIRTH (month, day and year): Oct 7 1861

7. AGE: Years 67 | Months 10 | Days 14 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS
10. NAME OF FATHER: John S. Walker
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Sarah Ryan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: Ada M. La Dow
(Address): Gifford, Ida.

15. Filed 8-22, 1929. E. E. Watts, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 21 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to July 12, 1929
that I last saw him alive on Aug. 20, 1929
and that death occurred, on the date stated above, at 3 a.m.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Intestines
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cancer of Stomach
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Frank Baker, D. O. D.
Aug. 21, 1929 (Address) Clarkston, Wash.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Melrose Cemetery Melrose Ida	8-22-1929
20. Undertaker: Star Hdwe & Impl Co	Address: Craigmont

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH U[illegible] CAUSE OF DEATH

N. B.—Every item of information should be carefully supp[illegible] in plain terms, so that it may be properly classified. Exac[illegible]

[illegible] OF DEATH

Registration District No. [illegible]

Primary Registration District No. 2069

State of Idaho
BOARD OF [illegible]
Bureau of Vital Statistics

File No. 67393

City of Malad (No. ..... St.) Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles H. Marston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Widowed (Write the word.)

6. DATE OF BIRTH

Mar - 2 1857
(Month) (Day) (Year)

7. AGE

72 Yrs. 5 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Teamster Rancher

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) New Hampshire

10. NAME OF FATHER Lorin Marston

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida Jenkins

(Address) Malad Ida

15. Filed 8-31 1929 J. M. Kerns
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 88B

Aug - 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1927, to Aug 1, 1929, that I last saw him alive on Aug 1, 1929, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows: Myocarditis (death sudden)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. P. Garst M. D.

Aug 1, 1929 (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Malad Ida | DATE OF BURIAL Aug 18 1929

20. UNDERTAKER J. Guy Berman | ADDRESS Malad Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED AUG 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67394

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Owyhee
City of Grand View

Registration District No. 74
Primary Registration District No. 21 5-1
(No.)

Local Registrar's No. 49

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mrs Ada Florence Garbutt

(a) Residence. No. 124 St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Married James Garbutt

6 DATE OF BIRTH (month, day and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	does not know		

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) -
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Millersburg Ohio

PARENTS
10 NAME OF FATHER William Hoxworth
11 BIRTHPLACE OF FATHER (city or town) (State or country) does not know
12 MAIDEN NAME OF MOTHER does not know
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant James Garbutt
(Address)

15 Filed aug 21, 1929 W J Ekenbeck
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH aug (Month) 25 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from aug 17, 1929, to aug 21, 1929,
that I last saw her alive on aug 21, 1929,
and that death occurred, on the date stated above, at 9-30 p m.

The CAUSE OF DEATH* was as follows:
Nephritis acute
does not know (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Phlebitis left leg.
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? do not know
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) Wm. J. Ekenbeck M. D.
aug 21, 1929 (Address) Grand View

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Portland Ore	
20. Undertaker C. G. Gacher	Address Mt. Home, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67395

PLACE OF DEATH

County of Power

City of American Falls, Idaho

Registration District No. 25

Primary Registration District No. 2072

Local Registrar's No. 22

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jay Miller

(a) Residence. No. Roy, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced. HUSBAND of (or) WIFE of Eva Miller

6. DATE OF BIRTH (month, day and year) Dec 28 1866

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8-7	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer W.E. Barkdull

9. BIRTHPLACE (city or town) (State or country) Wis

PARENTS

10. NAME OF FATHER Jacob Miller

11. BIRTHPLACE OF FATHER (city or town) (State or Country) U.S.

12. MAIDEN NAME OF MOTHER Sarah Warden

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) U.S.

14. Informant Fred Miller

(Address) Roy, Idaho

15. Filed Aug 27, 1929 Genevieve Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Struck by lightning
While tending Sheep

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas Davis Coroner

Aug 26, 1929 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F. American Falls	19

20. Undertaker Chas Davis Address American Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 25

Primary Registration District No. 2072

File No. 67396

County of Power

City of American Falls (No. ....., ... St.)

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry C Clarke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: 8 (Month) 29 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 12 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): ~~Infant~~

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Oliver Rey Clark

11. BIRTHPLACE OF FATHER (State or Country): La Crosse Wash.

12. MAIDEN NAME OF MOTHER: Mary Schaffer

13. BIRTHPLACE OF MOTHER (State or Country): Loveland Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed 8-30 1929 Gwenien Nott
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1610: 8 (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-29 — 1929 to 8-29 1929 that I last saw h.im. alive on 8-29 1929 and that death occurred on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:

Premature

..... (Duration) — Yrs. — mos. ..... ds.

Contributory (Secondary) —

..... (Duration) — yrs. — mos. ..... ds.

(Signed) J H Lynn M. D.

8-29 1929 (Address) 1140 N Johnson Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Premature

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Rockland, Idaho — DATE OF BURIAL: 8-30 1929

20. UNDERTAKER: Family — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67397

PLACE OF DEATH
County of Shoshone
City of Avery

Registration District No. ~~70~~ 127
Primary Registration District No. ~~121~~ 2400

Local Registrar's No. 6

(No. 164)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wilbert Irwin

(a) Residence. No. — St. —
(Usual place of abode)
Length of residence in city or town where death occurred. 19 yrs. 5 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or ~~divorced~~
HUSBAND of
~~(or) WIFE of~~ Amelia Irwin

6. DATE OF BIRTH (month, day and year) March 19-1849

7. AGE			If LESS than 1 day,
79 Years	11 Months	16 Days	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Railway Underloading Insp.
(b) General nature of industry, business, or establishment in which employed (or employer) Inspector-Retired
(c) Name of employer C. M. St. P. & P. R. R. Co.

9. BIRTHPLACE (city or town) Muncy - Penn.
(State or country)

PARENTS

10. NAME OF FATHER J. P. Irwin
11. BIRTHPLACE OF FATHER (city or town) Chester Co. Penn.
(State or Country)
12. MAIDEN NAME OF MOTHER Ann Mears
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Pennsylvania

14. Informant Mrs John Mackedon
(Address) Avery - Idaho

15. Filed Mar 7, 1929 C. E. Heald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1927, to March 8, 1929
that I last saw him alive on March 7th, 1929 (about 10th A.M.)
and that death occurred, on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH* was as follows:
Senility
(duration) 8 yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. E. Heald, M. D.
Mar. 7, 1929 (Address) Avery Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wn.	March 9 1929
20. Undertaker	Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 67298

Local Registrar's No. 84

RECEIVED AUG 15 1929

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. Wallace Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John V. Wright.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

6. DATE OF BIRTH: Nov. (Month) 1 (Day) 1877 (Year)

7. AGE: 51 Yrs. ... Mos. ... ds. ... IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business or establishment in which employed (or employer): Hecla Mining Co.

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF Father: not given

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Charlotte Craig

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Aug 6 1929 C. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1929 to July 24 1929 that I last saw him alive on July 24 1929 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) ... yrs. ... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) Wm. T. Smith M. D.

8/2/29 (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace, Idaho — DATE OF BURIAL: 8/6/29 19

20. UNDERTAKER: B. Marstell. — ADDRESS: Wallace Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67399

PLACE OF DEATH
County of Shoshone
near City of Clarkia

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 83

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1889

2. FULL NAME Gust Johnson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): ?

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6. DATE OF BIRTH (month, day and year): not known

7. AGE: Years about 50; Months —; Days —; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: labour
(b) General nature of industry, business, or establishment in which employed (or employer): Lumbering
(c) Name of employer: Ed. Rutledge Lumber Co

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10. NAME OF FATHER: not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): not known
12. MAIDEN NAME OF MOTHER: not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): not known

14. Informant: Ed Rutledge Lumber Co
(Address): Clarkia Ida

15. Filed Aug 1, 1929. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24, 1929, to —, 19..., that I last saw him dead alive on July 25, 1929 and that death occurred, on the date stated above, at 12:00 a.m.

The CAUSE OF DEATH* was as follows: Accidently killed by burning tree striking on the head and neck

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. Mowery Coroner
7/25, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Woodlawn
Date of Burial: July 30 1929

20. Undertaker: Mitchell Bros Morgan
Address: St Maries

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 15 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone — Registration District No. 70

City of Providence Hospital — Primary Registration District No. 1011

(No. ..... St.)

State. File No. 67400

Local Registrar's No. 82

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Glenn McDonald

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH ..... (Month) ..... (Day) ..... 1 (Year)

7. AGE: 82 Yrs. ..... Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Capelist
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF Father: Dennis McDonald

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Frances Orrick

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bruce S. McDonald
(Address) Coeur d'Alene, Ida.

15. Filed July 27 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 44 July 25th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1929, to July 1929, that I last saw him alive on July 25th 1929, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Internal Cancer
Involving Liver & Stomach

..... (Duration) ..... yrs. 4 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C S Stone M. D.

7/26 1929. (Address) Wallace, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 1 mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence Ryan Hotel Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Spokane, Wash. DATE OF BURIAL: 7/27 1929

20. UNDERTAKER: B G Worstell ADDRESS: Wallace Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 15 1929 DEP F IDAHO
PLACE OF DEATH B PUBLIC WELFARE
Cr TAL STATISTICS
E OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67401

County of Shoshone
City of
Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 81
(No. COUNTY INFIRMARY)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME WILLIAM McELMOIL

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 22, 1863

7. AGE: Years 65 | Months 10 | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10. NAME OF FATHER: not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): not known
12. MAIDEN NAME OF MOTHER: not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): not known

14. Informant: Mrs. Massey
(Address): CUSTODIAN, County Infirmary

15. Filed July 26, 1929 — P. Quigley, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1922, to July 26, 1929, that I last saw him alive on July 25, 1929, and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Ch. Int.

Nephritis (duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) James R Beam, M. D.
July 25, 1929 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace United Cemetaries	7-26-29 19

20. Undertaker	Address
O. L. Hart	Kellogg

RECEIVED OCT 8 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

James R. Bean

Wallace, Idaho

Sept. 26, 1929

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

E. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

William McElmoil who died July 24, 1929 at County Infirmary.

Information DESIRED in order to complete certificate.

Was he single, married, widowed, or divorced?

PLEASE ANSWER BELOW

Single

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 15 1929

PLACE OF DEATH

County of Shoshone

City of Wallace

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 70

Primary Registration District No. 1011

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67402

Local Registrar's No. 80

2. FULL NAME D. J. Williams

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

HH

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 1859

7. AGE Years 70 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mill Wright

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Eric Massey

(Address) Wallace Idaho

15. Filed July 23, 1929. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to July 2, 1929 that I last saw him alive on July 1, 1929 and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) James R Bean, M. D.

7/22, 1929 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Ida — Date of Burial July 5 1929

20. Undertaker R. L. Stout — Address Kellogg

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 15 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone Registration District No. 70

City of Wallace Primary Registration District No. 1011

(No. Providence Hosp. St.)

State File No. 67403

Local Registrar's No. 79

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Ramich 74a

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Unknown (Write the word)

6. DATE OF BIRTH: Oct. (Month) 70 (Day) 1869 (Year)

7. AGE: 60 Yrs. 3 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Not Know

10. NAME OF Father: ✓ ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓ ✓

12. MAIDEN NAME OF MOTHER: ✓ ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓ ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John P. Ferguson
(Address) Wallace, Idaho

15. Filed July 19 1929 J. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jul (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jul 14 1929 to Jul 15 1929 that I last saw him alive on Jul 15 1929 and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Paralysis left side
Extremities
(Duration) yrs. mos. hrs. ds.

Contributory (Secondary) Arteriosclerosis
(Duration) Seven yrs. mos. ds.

(Signed) Dr. Thompson M. D.

7/17 1929 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho

DATE OF BURIAL: July 19th 1929.

20. UNDERTAKER: M. C. Thornhill

ADDRESS: Kellogg, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 30 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Sept. 24, 1929

67403

Dr. Mowery

Wallace, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

E. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

Peter Ramich who died July 15, 1929 at Wallace, Idaho

Information DESIRED in order to complete certificate.

Was he single, married, widowed or divorced?

PLEASE ANSWER BELOW

unable to answer the above as no one knows early life

RECEIVED AUG 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67404

PLACE OF DEATH
County of Shoshone
City of Mullan

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 78

2. FULL NAME Ada A Carroll

(a) Residence. No. Mullan, Idaho St. Mullan, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of E. P. Carroll.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER D B Jennings.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known.
12. MAIDEN NAME OF MOTHER Daphney Waterman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa.

14. Informant E. P. Carroll.
(Address) Mullan, Idaho.

15. Filed July 17, 1929 E. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) July (Day) 10 (Year) 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928, to July 10, 1929
that I last saw her alive on July 9, 1929
and that death occurred, on the date stated above, at 1:30 a. m.
The CAUSE OF DEATH* was as follows:
Nephritis

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 17 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) F. Wolfe, M. D.
July 10, 1929 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho.	July 12 1929
20. Undertaker J. A. Bower	Address
Ward Undertaking Co.	Wallace, Idaho.

Every item or information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 15 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67405

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 77

31

2. FULL NAME Mrs George Alma Winchester
(a) Residence. No. Mullan, Idaho St. Mullan, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or ~~Divorced~~ (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of George Winchester

6. DATE OF BIRTH (month, day and year)

7. AGE Years 53 Months 2 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tels.

PARENTS
10. NAME OF FATHER — Franklin.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known.

14. Informant Jess. Winchester
(Address)

15. Filed July 3, 1929. S. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1929, to July 1, 1929
that I last saw her alive on July 1, 1929
and that death occurred, on the date stated above, at 7:30 p.m.
The CAUSE OF DEATH* was as follows:
Pulmonary Abscess
Tuberculosis Bronchiectasis
(Duration) Several yrs. mos. ds.
CONTRIBUTORY (Secondary) T.B. Pulmonary
(Duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of June 3
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Des Moines M. D.
7/2, 1929 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mullan, Idaho. Date of Burial July 3 1929

20. Undertaker J. A. Bower Ward Undertaking Co. Address Wallace, Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 15 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. Burke, Idaho. St.)

State File No. 67406
Local Registrar's No. 76
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ellis B. Griffin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	married

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
59 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business or establishment in which employed (or employer): Hecla Mining Co.

9. BIRTHPLACE (State or Country): not known

10. NAME OF Father: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. H. Edmiston,
(Address) Wallace, Idaho.

15.
Filed July 1 1929 J. R. Zuzy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) 7 (Day) 1 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw him alive on ..... 19.....,
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows: Crushed by falling ore car from stope in mine by motor engine. Quick. [illegible]

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Webb M.D.
7/2 1929 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Tieton, Washington	7/2 1929

20. UNDERTAKER	ADDRESS
Bruce G. Morstell	Wallace, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67107

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 10 11
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 85

70

2. FULL NAME John William Weyer

(a) Residence. No. Cottage Grove St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Mary E Weyer

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	6	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Cornelius Weyer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mary Weismiller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs Mary E. Weyer
(Address) Wallace Idaho

15. Filed Aug 5, 1929 E. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to Aug 1st, 1929
that I last saw him alive on Aug 1st, 1929
and that death occurred, on the date stated above, at 5.25 P m.

The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) E L Blume, M. D.
Aug 3rd, 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	Aug 5 1929
20. Undertaker J. A. Bever Ward Undertaking Co.	Address Wallace, Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 17 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 72
Primary Registration District No. 1211
(No. Wallace Hospital St.)

State File No. 67108
Local Registrar's No. 88

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

HP

2. FULL NAME Mary Nehl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F	White	Single

6. DATE OF BIRTH: March 29 (Month) (Day) 1879 (Year)

7. AGE: 50 Yrs. 5 Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk- Bookkeeper
(b) General nature of industry, business or establishment in which employed (or employer): C. J. Seelig Co.

9. BIRTHPLACE (State or Country): Standard Mich.

10. NAME OF Father: Adam Nehl

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Margret Seibel

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. C. J. Seelig
(Address) Wallace Ida.

15. Filed Aug 7 1929 L. A. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12th 1929 to Aug 4th 1929 that I last saw her alive on Aug 4th 1929 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Rt ovary with metastasis to liver?

(Duration) ..... yrs. 2 mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
8/6/29 (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 3 days. In the State 20 yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence: Wallace Ida.

19. PLACE OF BURIAL OR REMOVAL: Elding Mich. | DATE OF BURIAL: 8-7 1929

20. UNDERTAKER: Bruce G. Worstell | ADDRESS: Wallace Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED SEP 17 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 67409

Local Registrar's No. 87

1. PLACE OF DEATH

County of Shoshone

City of Mullen

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. Atlas Mine St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Barbara Jean Manier

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH: ~~August~~ April (Month) ~~5~~ 20 (Day) 1929 (Year)

7. AGE: Yrs. 3 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Mullen-Shoshone

10. NAME OF Father: Earl Manier

11. BIRTHPLACE OF FATHER (State or Country): Stanley Wisc.

12. MAIDEN NAME OF MOTHER: Dorthy G. Batt

13. BIRTHPLACE OF MOTHER (State or Country): Sand Point Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Manier
(Address) Mullen Ida

15.
Filed Aug 7 1929 L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 5 (Day) 1929 (Year) 101a

17. I HEREBY CERTIFY, That I attended deceased from ~~July 31~~ Aug 4 1929, to Aug 5 1929, that I last saw her alive on Aug 5 1929, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Bronchitis

2 weeks (Duration) ~~yrs. mos. ds.~~

(Signed) F. U. Rolf M. D.

Aug 5 1929 (Address) Mullan Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Cemetary

DATE OF BURIAL: Aug 7 1929

20. UNDERTAKER: Bruce G. Norstell

ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67410

PLACE OF DEATH
County of Shoshone
City of Prichard

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 88
174

2. FULL NAME William McIntosh
(a) Residence. No. Prichard, Idaho St. Prichard, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Oct. 18th 1899
7. AGE Years 29 Months 9 Days 24 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Winton Lumber Co.
9. BIRTHPLACE (city or town) (State or country) Superior Wisconsin

PARENTS
10. NAME OF FATHER Dan McIntosh
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ontario
12. MAIDEN NAME OF MOTHER Cathrine Campbell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Michigan

14. Informant Dan McIntosh
(Address) Coeur d'Alene Idaho
15. Filed Aug 12, 1929 L. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 11 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on Aug 10, 1929
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows: Burned in death in Hotel fire Prichard Idaho
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Mowry Corona M.
Aug 8, 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Shipped

19. Place of Burial, Cremation, or Removal Coeur d'Alene City Date of Burial 8/12/29 1929
20. Undertaker J. A. Lever Address Ward Undertaking Co. Wallace Idaho

RECEIVED SEP 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67411

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1911
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 89

58a

2. FULL NAME Mary Anna Sherman
(a) Residence. No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed.

6. DATE OF BIRTH (month, day and year) May-20-1876.

7. AGE Years 53 Months 2 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montreal.

PARENTS
10. NAME OF FATHER Eustache Ladouceau
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montreal
12. MAIDEN NAME OF MOTHER Elphire Nantel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montreal.

14. Informant Mr Jack Johnson
(Address) Burke, Idaho.

15. Filed Aug 16, 1929 J. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jul 10, 1929, to Aug 13, 1929
that I last saw her alive on Aug 12, 1929
and that death occurred, on the date stated above, at 5:20 A.m.
The CAUSE OF DEATH* was as follows: Pernicious Anemia
(duration) Dont Know yrs. mos. ds.
CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? none
(Signed) Dr. McNerry, M.D.
8/13, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial Aug 16 1929

20. Undertaker J. A. Bever Ward Mud. Co. Address Wallace, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67412

PLACE OF DEATH
County of Shoshone
City of ... Cedar Creek mine near Murray, Ida.
Registration District No. 70
Primary Registration District No. 1011
(No. ...)
Local Registrar's No. 70
(If death occurred in a hospital or institution, give its name instead of street and number.)

191

2. FULL NAME W. H. Welsh

(a) Residence. No. ... St. ...
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb. 4, 1888

7. AGE: Years 41 | Months 9 | Days 6 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Roseburg Ore.

PARENTS

10. NAME OF FATHER: Thomas Welsh
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Mary Warren
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Roseburg Ore.

14. Informant: Walter Welsh
(Address) Kellogg Ida

15. Filed 8 24, 1929. L. R. Quigley, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 29, to Aug 20, 29
that I last saw h... alive on ... 19...
and that death occurred, on the date stated above, at 9.30 AM.

The CAUSE OF DEATH* was as follows: Asphyxiating Carbon Monoxide Poisoning

(duration) ... yrs. 10 mos. Min

CONTRIBUTORY (Secondary) Accidental Cedar Creek mine near Murray Idaho
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? No Date of ...
Was there an autopsy? No
What test confirmed diagnosis? Knowledge of Accident

(Signed) H. C. Moorhead, M. D.
Aug 21, 1929 (Address) Wallace Ida County

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wash.	Aug 25 1929
20. Undertaker: P. S. Stout	Address: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 3 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

17412

H.C. Mowery
Wallace, Ida.

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

E. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

W.N. Welch who died Aug. 20, 1929
Cause of death given as "Asphyxiation (Carbon monoxide poisoning)

Information DESIRED in order to complete certificate.

DID THIS ACCIDENT OCCUR IN THE MINE?

PLEASE ANSWER BELOW was Cedar Creek mine
near Kenney Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67413

PLACE OF DEATH
County of Shoshone
City of ~~Wallace~~ Cedar Creek Mine near Murray, Ida.

Registration District No. 70
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 91

181

2. FULL NAME Lee
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, ~~or Divorced~~ (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 17 - 1896

7. AGE

Years	Months	Days	If LESS than 1 day,
33	3	2	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Salmon City
(State or country)

PARENTS

10. NAME OF FATHER Chas Lee
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Carolina

14. Informant Lena Lee
(Address) Kellogg Ida

15. Filed 8-24, 1929. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1929, to Aug 20, 1929
that I last saw h..... alive on ....., 19..
and that death occurred, on the date stated above, at 9:30 a.m.
The CAUSE OF DEATH* was as follows:
Asphyxiation, Carbon-Monoxide poisoning.
..... (duration) ..... yrs. ..... mos. 10 min
CONTRIBUTORY (Secondary) Accident of - Occurred in Cedar Creek Mine near Murray Ida.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Knowledge of accident.
(Signed) H. C. Morrow M. D.
Aug 22, 1929 (Address) Wallace Ida Coroner.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon City Ida
Date of Burial: Aug 25 1929

20. Undertaker: R. L. Stout
Address: Kellogg

RECEIVED MAR 3 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

17413

H.C. Mowery
Wallace, Ida.

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

Special Agent, Bureau of Census.

In reference to the death certificate of:

Russel Lee who died Aug. 20, 1929
Cause of death given as "Asphyxiation, carbon monoxide poisoning."

Information DESIRED in order to complete certificate.

DID THIS ACCIDENT OCCUR IN THE MINE? Yes Cedar Creek

PLEASE ANSWER BELOW Mine near Murray Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67414

PLACE OF DEATH

County of Shoshone

City of ~~Wallace~~ Cedar Creek Mine near Murray, Ida.

Registration District No. 92

Primary Registration District No. 1011

Local Registrar's No. 92

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

181

2. FULL NAME Harold Mathews

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 10 - 1900

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
29	3	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salmon

PARENTS

10. NAME OF FATHER Albert Mathews

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Withington

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant Lila Lee

(Address) Kellogg Id

15. Filed Aug 24, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1929, to Aug 20, 1929

that I last saw h..... alive on ....., 19....

and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Asphyxiation / Carbon Monoxide Poisoning

..... (duration) ..... yrs. ..... mos. 10 Min ds.

CONTRIBUTORY (Secondary) Accidental - Occurred in Cedar Creek Mine near Murray, Idaho (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Knowledge of Accident

(Signed) H. C. Mowery, M. D.

8/22/29 19.... (Address) Wallace Idaho Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salmon City Id — Date of Burial Aug 29 1929

20. Undertaker R. L. Stout — Address Kellogg

RECEIVED MAR 3 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

17414

H.C. Mowery
Wallace

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

Special Agent, Bureau of Census.

In reference to the death certificate of:

Harold Mathews whodied Aug. 20, 1929
Cause of death given as "Asphyxiation, carbon monoxide poisoning."

Information DESIRED in order to complete certificate.

DID THIS ACCIDENT OCCUR IN THE MINE? Yes Cedar Creek mine near Murray Idaho

PLEASE ANSWER BELOW

H C Mowery

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67415

PLACE OF DEATH

County of Shoshone

City of Clarkia

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 93

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Philbrook

(a) Residence. No. Camp 32 Clarkia Ida St. 304
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Un

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About 65 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant

(Address)

15. Filed Aug 28, 1929 C. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19 29

that I last saw him alive on Aug 14, 19 29

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

apparently Heart attack

(duration) Instant yrs. mos. ds.

CONTRIBUTORY (Secondary) alcoholism

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Mowery Coroner

8/19, 19 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67416

PLACE OF DEATH
County of Shoshone
City of Clarkia

Registration District No. 70
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 94

1889

2. FULL NAME Dan Raseta
(a) Residence. No. Rutledge Camp 31 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE Years 38 Months — Days — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Woodsman
(c) Name of employer Rutledge Timber Co
9. BIRTHPLACE (city or town) (State or country) Serbia

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Rutledge Timber Co Clarkia Ida
(Address)
15. Filed Aug 28, 1929. S. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 22 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw him alive on Aug 22, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows: Crushed to death
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Rolling Log Instant
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H C Mowrey Jr M. D.
8/23, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane Wash
Date of Burial 19
20. Undertaker Hennessey and Calloway
Address Spokane Wash

RECEIVED SEP 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67417

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 12-11
Local Registrar's No. 95
(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard Scott
(a) Residence. (Usual place of abode) One mile West of Osburn
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. Single, Married, Widowed, or Divorced, (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE — Years | Months | Days | If LESS than 1 day, ____ hrs. or ____ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer in Coal mine
(b) General nature of industry, business, or establishment in which employed (or employer): Underground
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant
(Address)
15. Filed Aug 24, 1929 — L. R. Quigley, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 18 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929, to Aug 18, 1929, that I last saw him alive on Aug 18, 1929, and that death occurred, on the date stated above, at 12 N M.
The CAUSE OF DEATH* was as follows:
Valvular Heart
(duration) years yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
8/29/29 (Signed) Alfred R Bean, M. D.
(Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Ida	Aug 24 1929
20. Undertaker: R. L. Stout	Address: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67418

PLACE OF DEATH
County of Shoshone
City of Clarkia

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 96

(No. 304)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John W Landon
(a) Residence. No. Clarkia Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Wid

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 65			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer) Edw Rutledge Timber Co
(c) Name of employer Camp No 26 Clarkia Idaho

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Edw Rutledge Timber Co
(Address) Clarkia Ida

15. Filed Aug 28, 1929. T. L. Lindsley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred on the date stated above, at m.

THE CAUSE OF DEATH* was as follows:
Wound Left inguinal
Appendicitis Acute
Rupture
(duration) hrs. Instantaneous
CONTRIBUTORY (Secondary) Alcoholism
Nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) N. McVeigh Coroner (M.D.)
8/29, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Maries Ida	Aug 28 1929
20. Undertaker	Address
Geo B Mitchell	St Maries Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. REC'D SEP 17 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 67419

Local Registrar's No. 97

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

2. FULL NAME Mrs Eva Dell Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: June (Month) 27 (Day) 1888 (Year)

7. AGE: 41 Yrs. ~~41~~ Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Watson County Iowa.

10. NAME OF Father: Chas. Ganoung W

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Vernie Woodworth

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Deceased
(Address) Big Creek Idaho

15. Filed Sept 1 1929 T. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1929, to Aug 29 1929 that I last saw her alive on Aug 28 1929 and that death occurred on the date stated above, at 1215 a M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) Operative repair of Abdominal Hernia.

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Max T. Smith M. D.

8/29 1929 (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Cemetery — DATE OF BURIAL: 9-1 1929

20. UNDERTAKER: Bruce G. Worstell — ADDRESS: Wallace Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 30 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Sept. 24, 1929

67419

Max T. Smith
Wallace, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

E. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

Mrs. Eva Dell Anderson who died Aug. 29, 1929 at Wallace, Idaho.

Information DESIRED in order to complete certificate.

Was she single, married, widowed or divorced?

PLEASE ANSWER BELOW

Married

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67480

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 41

1 20

2. FULL NAME Spencer William Anderson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced *(write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 18-1898

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
31	3	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Bunkerhill Co

9. BIRTHPLACE (city or town) (State or country) Lake Mills Iowa

PARENTS

10. NAME OF FATHER Sivert S Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Mary Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Thos. C. Anderson
(Address) Moscow Ida

15. Filed Aug. 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22, 1929, to Aug. 27, 1929, that I last saw him alive on Aug, 1929 and that death occurred, on the date stated above, at 12:30 p m.

The CAUSE OF DEATH* was as follows:
Peritonitis
..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Appendicitis
..... (duration) ..... yrs. ..... mos. 6 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical & Operative
(Signed) T. W. Laraway, M. D.
Aug 30, 1929 (Address) Kellogg, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Ida
Date of Burial Aug 29 1929

20. Undertaker R. L. Stout
Address Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67421

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No.) 186
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 40

2. FULL NAME Hans Helgeson
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May 9, 1875
7. AGE Years 54 Months 3 Days 18 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stationary Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Norway
PARENTS
10. NAME OF FATHER Mr. Helgesen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Norway
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway
14. Informant Brita Helgeson
(Address) 415 South Cowley Spokane Wash.
15. Filed Aug. 28, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 27 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 10:45 A.m.
The CAUSE OF DEATH* was as follows:
mine accident - Fractured Skull
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. C. Mowery Coroner
8/28, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane Wash. Date of Burial Aug 30 1929
20. Undertaker M. C. Thornhill Address Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67422

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 39

PLACE OF DEATH
County of Shoshone
City of Kellogg
(No.); (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harold Wilbur Durbin

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 5, 1910

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	10	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work millman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Troy Idaho

PARENTS

10. NAME OF FATHER J. L. Durbin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Bertha Skeen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) West Virginia

14. Informant Logan Durbin
(Address) 136 N. Cameron

15. Filed Aug 29, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h~~im~~ ~~alive on~~ Aug 20, 1929
and that death occurred, on the date stated above, at ~~before~~ 6:40 a.m.

The CAUSE OF DEATH* was as follows:
Accident, Buried in a bin of crushed ore. Went into a bin because ore that was not feeding to bar it down. Ore suddenly came so fast he could not get out of it and was completely burried.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Geo H Kennett, M. D.
Aug. 28, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal	Date of Burial
Kellogg, Idaho	Aug 23 1929
20. Undertaker	Address
M. C. Thornhill	Kellogg, Ida.

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67123

Local Registrar's No. 38

PLACE OF DEATH
County of Shoshone
City of Kellogg
Registration District No. 123
Primary Registration District No. 2201
(No. 101a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Agnes Sophia Peterson

(a) Residence. No. Kellogg State St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 1 - 1907

7. AGE	Years	Months	Days	If LESS than 1 day,
	21	11	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Raymond Wash.

PARENTS

10. NAME OF FATHER John Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland
12. MAIDEN NAME OF MOTHER Emma Ogren
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant Emma Peterson
(Address) Kellogg Ida

15. Filed Aug 12, 1929. Mrs. Helen M. Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1929, to Aug 11, 1929
that I last saw her alive on Aug 11, 1929
and that death occurred, on the date stated above, at 1:05 a. m.
The CAUSE OF DEATH* was as follows:
Double lobar pneumonia
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Geo. T. Kennett, M. D.
Aug 13, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Raymond Wash.	Aug 15 1929
20. Undertaker	Address
R. L. Stout	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67424

PLACE OF DEATH
County of Shoshone
City of Kellogg.

Registration District No. 123
Primary Registration District No. 2201
(No. 129)
Local Registrar's No. 37

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lloyd White Drais.

(a) Residence. No. 305 Maple St. St.
(Usual place of abode)
Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Mable Drais.

6. DATE OF BIRTH (month, day and year) Sept 30 - 1871

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Pinkerville Co.

9. BIRTHPLACE (city or town) (State or country) Harrisonville Mo.

PARENTS

10. NAME OF FATHER L. J. Drais
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ? ?
12. MAIDEN NAME OF MOTHER Lucy Shelton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ? ?

14. Informant Mable Drais
(Address) Kellogg Ida

15. Filed Aug 2, 1929 Mrs. Helen O'Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 30, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to July 29, 1929, that I last saw him alive on July 29, 1929, and that death occurred, on the date stated above, at 8:55 a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? urine
(Signed) Geo. H. Kennett, M. D.
Aug 2, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Ida	Aug-2 1929
20. Undertaker	Address
R. L. Grant	Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1929

PLACE OF DEATH

County of Teton

City of Driggs

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 7-7

Primary Registration District No. 2176

(No. 48B)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67425

Local Registrar's No. 8

2. FULL NAME William J. S. Curtiss

(a) Residence. No. #4 Laural Parkway St. Chevy Chase, Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. W. J. S. Curtiss

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	76	—	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Howard S. Engels

(Address) Greenwich Conn.

15. Filed 8-15-, 1929 Martha Mosher Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929 to Aug 15, 1929 that I last saw ~~him~~ alive on Aug 15, 1929 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

~~Was there an autopsy?~~ Brought to Boston

What test confirmed ~~diagnosis~~? Embalmer

(Signed) Chas. W. Huff, M. D.

8-15, 1929 (Address) Jackson Wyo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boston Mass.	— 19—

20. Undertaker C B Eckerall Address Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67426

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Twin Falls, Registration District No.

City of " " Primary Registration District No.

Local Registrar's No.

(No. Co. Gen Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME George Howe

(a) Residence. No. 146 4th ave E. St. 74a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years 47 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Auto Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant H. E. Diers Secty B.P.O.E.
(Address) Twin Falls Ida.

15 Filed ....., 19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. (Month) 6 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 7th, 1929, to Aug 6, 1929, that I last saw him alive on Aug 6, 1929, and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. 1 ds

CONTRIBUTORY (Secondary) Arteriosclerosis Genera

(duration) ? yrs. ..... mos. ..... d

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical - X ray S & Laboratory

(Signed) Duncan L Hixon M.

Aug 7th, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Twin Falls — Date of Burial Aug 8 1

20. Undertaker J J Grossman — Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67427

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Twin Falls Registration District No.

City of " " Primary Registration District No.

Local Registrar's No. 2067

(No. 344 2nd Ave No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Elizabeth L Jones

(a) Residence. No. 344 2nd Ave No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

88 B

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) June 15 1852

7 AGE Years 77 Months 1 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER William Latham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Chas E. Jones

(Address) 344 2nd Ave No. City

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 6 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1929, to Aug 6th, 1929, that I last saw her alive on Aug 6th, 1929, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration (myocardial with Mitral regurgitation chronic

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis general.

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Duncan L. Hexafeld M. D.

8/8/29, 19..... (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Queen City Mo

Date of Burial 19

20. Undertaker J. F. Grossman

Address Twin Fal

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67428

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1 80
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2097

183

2. FULL NAME Jack Lemon

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE: 55 Years | Months: — | Days: — | If LESS than 1 day, ... hrs. or — min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sheepheardder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): —

14. Informant .....
(Address)

15. Filed ....., 19.... ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 12 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Gun Shot
in Hands of H Moore (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) T C Drake Coroner, M. D.
....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wesley Sidon | Date of Burial: July 19

20. Undertaker: T C Drake | Address

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67429

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Twin Falls Registration District No. 37

City of " " Primary Registration District No. 1085

(No. Co. Gen. Hosp.)

Local Registrar's No. 2096

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ruby Tiffney 41

(a) Residence. No. 511 Main St E. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov. 13

7 AGE Years 26 Months 7 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Arizona

PARENTS

10 NAME OF FATHER Joseph Weech

11 BIRTHPLACE OF FATHER (city or town) (State or country) Arizona

12 MAIDEN NAME OF MOTHER Myrtle Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Arizona

14 Informant Mrs Myrtle Weech
(Address) 511 Main St. East.

15 Filed 7-22, 1929 Dr. D. McCowell By H. M. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 12 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1929, to July 12, 1929, that I last saw her alive on July 11th, 1929, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) ..... yrs. one mos. 10 ds.

CONTRIBUTORY (Secondary) Inflammation of mouth (duration) ..... yrs. ..... mos. 40 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Lamb, M. D.

....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Twin Falls

Date of Burial July 14 1929

20. Undertaker P. J. Grossman

Address Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67430

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No.) 133
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2065

2. FULL NAME J. E. Nelson
(a) Residence. No. Bull Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 23 1866

7. AGE Years 63 Months 6 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER S. Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Emma Svenson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Harold Nelson
(Address) Bull Idaho

15. Filed 8-5, 1929. David M. Cowgill H. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7-28 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-25, 1929, to 7-28, 1929
that I last saw him alive on 7-28, 1929
and that death occurred, on the date stated above, at 8:40 P. m.
The CAUSE OF DEATH* was as follows: Following Cholecystectomy and appendendectomy.
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Hypostatic Pneumonia
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? yes Date of 7-25-29
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) Geo. Jennings M. D.
7-29, 1929 (Address) Bull, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bull Cemetery — Date of Burial 7/31 1929
20. Undertaker Newell D. Rugg — Address Bull Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 674[illegible]

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2063

2. FULL NAME Opal Ruth Williams

(a) Residence. No. Filer St. 11a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 2 / 1907

7. AGE Years: 21 Months: 8 Days: 30 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nebraska

PARENTS

10. NAME OF FATHER: C G Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Nebraska
12. MAIDEN NAME OF MOTHER: Minerva Page
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: C G Williams
(Address): Filer

15. Filed, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 19, 1929, to Aug. 1, 1929
that I last saw her alive on Aug. 1, 1929
and that death occurred, on the date stated above, at 21.30 P m.

The CAUSE OF DEATH* was as follows:
Influenza Infect[illegible]
Bronchitis ~~Lymph Adenitis~~
Chorangitis Lymph adenitis
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical & Laboratory
(Signed) J R Morgan, M. D.
Aug 3, 1921 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer
Date of Burial: Aug 4 1929

20. Undertaker: F E Drake
Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67432

Registration District No.

Primary Registration District No.

Local Registrar's No. 2061

(No. County Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Donald Frey

(a) Residence. No. Kimberly St. 133

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 12 / 1927

7. AGE Years 1 Months 7 Days 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER R. L. Frey

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo

12. MAIDEN NAME OF MOTHER Verna DeWitt

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant R. L. Frey

(Address) Kimberly

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1929, to July 31, 1929

that I last saw him alive on July 31, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Extrophy of Bladder

(duration) 1 yrs. 7 mos. 19 ds.

CONTRIBUTORY (Secondary) acute cardiac dilatation

(duration) yrs. mos. 1/10 ds.

18. Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of July 31/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) George E Hally, M. D.

July 31, 1929 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Aug 1 1929

20. Undertaker: F. E. Drake — Address: Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED AUG 12 1929

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67433

PLACE OF DEATH
County of Twin Falls, Registration District No.
City of Twin Falls, Primary Registration District No.
(No.)
Local Registrar's No. 2059

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Celia L. Holler

(a) Residence. No. 110-3Rd. Ave So St. 131
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug. 11th. 1860

7 AGE 68 Years 11 Months 18 Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10 NAME OF FATHER Seth H. Durfey

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Syble Poppleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio.

14 Informant H.M. Holler
(Address) 110 . 3Rd. Ave, so

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 28Th. 29
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1927, to July 28, 1929, that I last saw her alive on July 28, 1929, and that death occurred, on the date stated above, at 645pm.

The CAUSE OF DEATH* was as follows:
Hypernephroma of Kidneys
(duration) 2 yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)
(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec. 27/192
Was there an autopsy? No
What test confirmed diagnosis? Operation.
(Signed) A.W. Wilson, M. D
July 29, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Twin Falls, Idaho | Date of Burial: July 30 19 2

20. Undertaker: F.J. Grossman, Twin | Address: Falls,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67434

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No. 2058

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emily J Flowers 90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 12 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	9	14	

8. OCCUPATION OF DECEASED —

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) Mo
(State or country)

PARENTS

10. NAME OF FATHER Booth

11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14. Informant J B Drake
(Address) Twin Falls

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on , 19 , to July 27 , 1929
that I last saw her alive on July 27 , 1929
and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:
Valvular heart disease

(duration) 7 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E. D. Weaver, M. D.
, 19 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	July 29 1929

20. Undertaker J C Drake Address Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67435

County of Twin Falls

City of Rogerson,

Registration District No. 37

Primary Registration District No. 1085

(No. .....)

Local Registrar's No. 2055

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Luke Jacob Lanting

(a) Residence. No. Rogerson, Idaho. St. 160

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 23.1929

7 AGE Years | Months | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rogerson Idaho.

PARENTS

10 NAME OF FATHER John Lanting,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holand

12 MAIDEN NAME OF MOTHER Grace Visser,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holand,

14 Informant John Lanting,

(Address) Rogerson.

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 1st (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to 7/1, 1929, that I last saw him alive on 7/1, 1929, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Icterus gravis

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. D. Weaver, M. D.

....., 19..... (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Twin Falls, Idaho

Date of Burial: July.2 19

20. Undertaker: P.J. Grossman,

Address: Twin Falls,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No.:

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67436

Local Registrar's No. 2054

2. FULL NAME John F, Denton,

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 23/1909

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
19	10	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER D, M, Denton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Okla

12. MAIDEN NAME OF MOTHER Olive Trendly

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant John Trendly

(Address) Hollister

15. Filed 7-20, 1929 Dr. D. McConnell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July. 19/29
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 17, 1929, to July 19, 1929

that I last saw h— alive on July 17, 1929

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute endocarditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W. Wilson, M. D.

July 20, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
~~Salt Lake City~~ Oakland San Diagake City Cal	19

20. Undertaker F, F, Drake — Address Twin F

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67437

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1080

Local Registrar's No. 2053

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Baby Roberts

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe mal
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July 19 / 29

7. AGE: — Years: — Months: — Days: — If LESS than 1 day, 12 hours hrs. or min.

8. OCCUPATION OF DECEASED —
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10. NAME OF FATHER: Lee Roberts
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo
12. MAIDEN NAME OF MOTHER: Dorothy Claytond
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo

14. Informant: Lee Roberts
(Address): Denver, Colo

15. Filed 7-20, 1929. Dr. D. M. Cocagill By H. M. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19, 1929, to July, 1929
that I last saw her alive on July 19, 1929
and that death occurred, on the date stated above, at 8:30 P m.
The CAUSE OF DEATH* was as follows:

Premature (6 mo)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): not fully developed

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H. N. Lee, M. D.
7-20-, 1929 (Address) Twin Falls Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer
Date of Burial: July 21 19

20. Undertaker: F. E. Drake
Address: T Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67438

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No. 37
Primary Registration District No. 1080

Local Registrar's No. 2052

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

182

2. FULL NAME Chas McNeal

(a) Residence. No. Filer St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Unable to get date

7. AGE 13 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Ercell McNeal
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Dorothy McNichol
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Mrs Williams
(Address) Twin Falls

15. Filed 7-20-2, 1929. Dr D McCowgill By Mrs W. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Accidental Drowning (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) F E Drake Coroner, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Filer | Date of Burial July 17 1929

20. Undertaker F E Drake | Address T Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67439

PLACE OF DEATH

County of Twin Falls

City of Filer

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No. 2051

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

182

2. FULL NAME Viola Mc Neal

(a) Residence. No. Filer St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fe	White	Single,

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) – Unable to get date

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
13			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Ercell Mc Neal

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo

12. MAIDEN NAME OF MOTHER Dorothy Mc Nickol

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Mrs Williams
(Address) Twin Falls

15. Filed 7-20-2, 1929. Dr D McCaugell By H M W Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July, 14 /29 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Accidental
Drowning

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) F. E. Drake Coroner, M. D.

....., 19..... (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Filer	Jul, 17 19

20. Undertaker F. E. Drake Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67440

PLACE OF DEATH
County of Twin Falls
City of Rural Rt

Registration District No. 37
Primary Registration District No. 1085
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2050

2. FULL NAME Agnes De Klotz 1a
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 7 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Gilbert F. De Klotz

6. DATE OF BIRTH (month, day and year) June 14, 1893

7. AGE: Years 36 | Months | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Roodhouse Illinois

PARENTS

10. NAME OF FATHER James C. Starkey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Berhatta Illinois
12. MAIDEN NAME OF MOTHER Jessie M Shield
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bloomington Ill

14. Informant J. C. Starkey
(Address)

15. Filed 7-25-, 1929 David Cowgill H.M.W. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1929, to July 17, 1929
that I last saw her alive on July 17, 1929
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows: Typhoid fever.
..... (duration) ..... yrs. 1 mos. 5 ds.
CONTRIBUTORY (Secondary) Hemorrhage — + perforation
..... (duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) H W Wilson, M. D.
July 20, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer | Date of Burial: July 19 1929

20. Undertaker: F. E. Drake | Address: T Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67441

PLACE OF DEATH
County of Twin Falls
City of Twin Falls Co. Hospital

Registration District No. 39
Primary Registration District No. 2087
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

143 B

2. FULL NAME Inez Voyce
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ezra Voyce

6. DATE OF BIRTH (month, day and year) Apr. 3rd 1896

7. AGE Years 33 Months 4 Days 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buffalo. Mo.

PARENTS
10. NAME OF FATHER Joseph Braunwell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Evelyn Hildebrand
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Ezra Voyce
(Address) Buhl, Ida.

15. Filed 8-23, 1929 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 — 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-22-, 1929, to 8-22, 1929
that I last saw her alive on 8-22, 1929
and that death occurred, on the date stated above, at 5.15 P m.
The CAUSE OF DEATH* was as follows:
Following operation for ectopic pregnancy & fibroid tumor of uterus.
(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? yes Date of 8-22-29
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Geo. Jennings, M. D.
8-23-, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl, Ida. Date of Burial Aug 25 1929

20. Undertaker J. Johnson Address Buhl Ida

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67442

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Albert Jermiah Downey 43

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May-21-1881

7. AGE: Years 48 | Months 2 | Days 21 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Georgia

PARENTS

10. NAME OF FATHER: Andrew Jackson Downey
11. BIRTHPLACE OF FATHER (City or town) (State or Country): Georgia
12. MAIDEN NAME OF MOTHER: Mary E Knight
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Georgia

14. Informant: Mrs L E Downey
(Address): Buhl Idaho

15. Filed 8-14, 1929 J. F. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to Aug 13, 1929, that I last saw him alive on Aug 3, 1929, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:
Carcinoma (sub-maxillary region)
(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of About 15 mos
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) F L Berry M. D.
Aug 13, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise Idaho	8/14 1929

20. Undertaker: Wells & Rugg Address: Buhl Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67443

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME James Machacek

(a) Residence. No. ..... St. 170
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Antonie Machacek

6. DATE OF BIRTH (month, day and year)

7. AGE Years 47 Months 5 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS
10. NAME OF FATHER Antan Machacek
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bohemia
12. MAIDEN NAME OF MOTHER Louise Wolf
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bohemia

14. Informant Coroner's investigation
(Address)

15. Filed 8-12, 1929 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 9th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——, 19..., to ——, 19...
that I last saw h— alive on ——, 19...
and that death occurred, on the date stated above, at 1 30 A m.
The CAUSE OF DEATH* was as follows:
Gunshot wound through head, self inflicted
..... (duration) ..... yrs. ..... mos. 1½ hrs.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ——
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Coroner's investigation
(Signed) George C. Halley, M. D.
Aug 9, 1929 (Address) Deputy Coroner Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Idaho — Date of Burial Aug 10 1929

20. Undertaker L. Johnson — Address Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1929

PLACE OF DEATH

County of Twin Falls

City of Buhl

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 39

Primary Registration District No. 2087

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67444

Local Registrar's No. .....

54a

2. FULL NAME Billy Ryan

(a) Residence. No. 324 Broadway St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed.

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Widowed.

6. DATE OF BIRTH (month, day and year): Nov 7 - 1859

7. AGE: Years 69, Months 8, Days 25. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Virginia.

PARENTS

10. NAME OF FATHER: Mr Height.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....

12. MAIDEN NAME OF MOTHER: Don't know.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia.

14. Informant: Clyde Ryan
(Address) .....

15. Filed Aug 2, 1929 J. H. Murphy. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927, to Aug 1, 1929 that I last saw her alive on Aug 1, 1929 and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows: Pernicious Anemia.

..... (duration) 2+ yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory

(Signed) J. H. Murphy, M. D.

Aug 2, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation~~, or Removal: Osceola Neb. H B Evans — Date of Burial 19

20. Undertaker: — Address: Buhl

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67445

PLACE OF DEATH
County of Twin Falls
City of Gooding

Registration District No. 39
Primary Registration District No. 2087
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martha Lee Reynolds

(a) Residence. No. Gooding Idaho St. 90
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 12 1922

7. AGE	Years	Months	Days	If LESS than 1 day,
	6	9	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10. NAME OF FATHER R. S. Reynolds
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Stella Nelson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant M. Reynolds
(Address) Buhl Idaho

15. Filed 8-3, 1929 J. T. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to , 19
that I last saw him alive on , 19
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:
Paralysis of Heart.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Physical
(Signed) J. T. Murphy, M. D.
8-3, 1929 (Address) Buhl

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	8/3 1929

20. Undertaker Emerald L. Rugg Address Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67446

PLACE OF DEATH
County of Jr Falls
City of Jr Falls

Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.

(No.) 206
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Durbin County Hospital
(a) Residence. No. 558 5 ave. W. Ast.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept 5/24
7. AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Still Born
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER E P Durbin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Marguerit Fehrenbach
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant E P Durbin
(Address) Twin Falls

15. Filed 9-7-, 1929 David Cavagnell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5, 1929, to Sept 5, 1929
that I last saw him alive on Sept 5, 1929
and that death occurred, on the date stated above, at 5:20 A.M.
The CAUSE OF DEATH* was as follows:
Premature
(duration) yrs. 5 mos. 00 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? none
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Exam
(Signed) H N Leete, M. D.
9-5-, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Teler Cemetery Date of Burial Sept 1929
20. Undertaker F C Drake Address Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

175142 D

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67447

PLACE OF DEATH
County of Sun Falls
City of Filer

Registration District No. 37
Primary Registration District No. 2080
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

74a

2. FULL NAME John Kaster
(a) Residence. No. Clover St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): March 30/1859

7. AGE: 70 Years, 5 Months, 2 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Farming
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10. NAME OF FATHER: Claus Kaster
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Mrs. John Kaster
(Address): Clover Idaho

15. Filed 9-7, 1929 David Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Apoplexy — Dropped dead was dead when I arrived
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) A. A. Newberry, M. D.
Sept 3, 1929 (Address) Filer Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clover Cemetary — Date of Burial: Sept 5 1929

20. Undertaker: F. E. Drake — Address: Sun Falls

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67448

PLACE OF DEATH
County of Twin Falls,
City of Twin Falls,

Registration District No. 37
Primary Registration District No. 2085

Local Registrar's No.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ralph G. Toolson

24

(a) Residence. No. Twin Falls Co. Gen'l Hospital St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of *****

6. DATE OF BIRTH (month, day and year) Dec. 17, 1916

7. AGE	Years	Months	Days	If LESS than 1 day,
	12	8	13	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Driggs, Idaho

PARENTS

10. NAME OF FATHER Joseph G. Toolson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Mable Millyard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant J. G. Toolson,
(Address) Twin Falls, Idaho

15. Filed 9-2-, 1929 David Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 1, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 23, 1929 to Sept. 1, 1929
that I last saw him alive on Sept. 1, 1929
and that death occurred, on the date stated above, at 8:15 P. m.
The CAUSE OF DEATH* was as follows:
Cerebro-spinal meningitis, meningococcic.

..... (duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) none

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? not known
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Lab. findings, & clinical course
(Signed) Geo C Hally, M. D.
Sept. 3, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Idaho	Sept. 4 1929
20. Undertaker P. J. Grossman	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 87449

PLACE OF DEATH
County of Twin Falls
City of do.

Registration District No. 37
Primary Registration District No. 1080
(No. 162)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

2. FULL NAME Margie Higginson

(a) Residence. No. 135-6 and West St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 2-1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	31	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Twin Falls, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Victor Higginson
11. BIRTHPLACE OF FATHER (city or town) Wyoming
(State or Country)
12. MAIDEN NAME OF MOTHER Mildred Large
13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)

14. Informant Victor Higginson
(Address) Twin Falls, Idaho

15. Filed 9-5-, 1929 David Corwin
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1- 1929 to Sept 1 1929
that I last saw h alive on Sept 1 1929
and that death occurred, on the date stated above, at 7:30 A. m.
The CAUSE OF DEATH* was as follows:

Uremic retention

(duration) yrs. mos. 1 ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Dont Know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) H H Lee, M. D.
Sept 1, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls cemetery	Sept 2 1929
20. Undertaker F. C. Drake	Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67450

PLACE OF DEATH

County of Twin Falls
City of " "

CERTIFICATE OF DEATH

Registration District No. 37
Primary Registration District No. 2085
(No. RFD # 2)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

2. FULL NAME Daniel McDowell

(a) Residence. No. RFD 1 St. 74a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 14 1849

7 AGE Years 80 Months 3 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10 NAME OF FATHER Elisah McDowell
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind
12 MAIDEN NAME OF MOTHER Lula Taylor
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant J. W. McDowell
(Address) Twin Falls RFD # 2

15 Filed 9-7-, 1929 David Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 31 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 7th, 1929, to Aug 31, 1929, that I last saw him alive on Aug 29, 1929, and that death occurred, on the date stated above, at 8:15 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis General (duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Duncan L Hernandez M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Springerton Ill. Date of Burial 19

20. Undertaker P J Grossman Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67451

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2082
(No. T. F. Co Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 162 Davis

2. FULL NAME Ivan Carrol Hine
(a) Residence. No. 2½ miles S.E. of Kimberly St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 18-1929

7. AGE Years 0 Months 0 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho.
(State or country) Twin Falls.

PARENTS

10. NAME OF FATHER Harold Hine
11. BIRTHPLACE OF FATHER (city or town) Iowa
(State or Country)
12. MAIDEN NAME OF MOTHER Bernice Webb.
13. BIRTHPLACE OF MOTHER (city or town) Idaho.
(State or Country)

14. Informant Harold Hine
(Address) Kimberly Idaho

15. Filed 9-7, 1929 David Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1929, to Aug. 19, 1929
that I last saw him alive on Aug. 18, 1929
and that death occurred, on the date stated above, at 4:00 A m.
The CAUSE OF DEATH* was as follows:
Congenital Atelectasis
(duration) 16 hrs yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) M. O. Davis, M. D.
Aug 20, 1929 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Cemetery
Date of Burial Aug 20 1929

20. Undertaker F. C. Drake
Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67452

PLACE OF DEATH
County of Twin Falls.
City of Do.
Registration District No.
Primary Registration District No.
(No. Twin Falls. Co. Hospital)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Aubrey C. Brown 131
(a) Residence. No. Tulsa, Oklahoma St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Gladys Brown

6. DATE OF BIRTH (month, day and year) Oct 21 1890

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	10	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Purdy, Mo.

PARENTS
10. NAME OF FATHER Charles Luther Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Virginia Carlin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant J. L. Tolinger
(Address) Twin Falls, Idaho.

15. Filed 9-1-, 1929 David Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-19, 1929, to 8-23, 1929
that I last saw him alive on 8-23, 1929
and that death occurred, on the date stated above, at 5:30 P. m.
The CAUSE OF DEATH* was as follows:
Acute Thyroiditis

(duration) - yrs. - mos. 2 ds.
CONTRIBUTORY (Secondary) Pathology of stomach-liver & gall bladder-pancreas and right kidney (duration) At least several mos. — ds.

18. Where was disease contracted if not at place of death? Do not know
Did an operation precede death? Yes Date of 8-19-29
Was there an autopsy? Yes
What test confirmed diagnosis? Examination at autopsy
(Signed) P A Ewen. M. D.
8-24, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19

20. Undertaker	Address
Paul Beers	Twin Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67483

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No.

Primary Registration District No.

(No. ~~Eden, Idaho~~ T. F. Co. Hospital

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

Clouch

117

2. FULL NAME Marvin Lester Brauburger

(a) Residence. No. Eden, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 16 - 1926

7. AGE Years 3 Months 6 Days 7 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER J. L. Brauburger

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Minnie Sayvers

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant J. L. Brauburger
(Address) Eden Idaho.

15. Filed 9 - 1 - 1929 David Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ 1/2 hour before his death only, 19

that I last saw him alive on Aug 23, 1929

and that death occurred, on the date stated above, at 9 PM m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix
general peritonitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Eden, Idaho

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W. Clouch M. D.
by H. W. Wilson

Aug 24, 1929 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Eden Cemetery — Date of Burial 8/25 1929

20. Undertaker Paul Bell — Address T. F. Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 10 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 2085

(No. Twin Falls Co. Gen. Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67454

Local Registrar's No.

2. FULL NAME Irene Morgan Knott. 90

(a) Residence. No. Eden St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James C. Knott

6. DATE OF BIRTH (month, day and year) May 14-1883

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	3	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Southampton Canada

PARENTS

10. NAME OF FATHER E. C. Morgan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Mary Gilbert

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant James C Knott

(Address) Eden, Idaho.

15. Filed 9-1-, 1929 David Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 15 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug-1, 1929, to Aug-15, 1929

that I last saw h-s alive on Aug-15, 1929

and that death occurred, on the date stated above, at 12:10 Pm

The CAUSE OF DEATH* was as follows:

Cardio-Vascular-renal disease

(Chronic Nephritis (duration) yrs. mos. ds

CONTRIBUTORY (Secondary) Hypertension Cystitis)

(duration) yrs. mos. 14 ds

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes no Date of July 2029

Was there an autopsy?

What test confirmed diagnosis? clinical & gross

(Signed) J M Dawes, M. D

Aug 16, 1929 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	8-16 192

20. Undertaker White Mortuary Inc

Address

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67455

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. Twin Falls County Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louis James Hubbell

100a

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Violet Hubbell

6. DATE OF BIRTH (month, day and year): Jan 10 1881

7. AGE: Years 48, Months 6, Days 20. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Farm work
(c) Name of employer: Marmelian & Young

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: James Hubbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Harry G. Hubbell
(Address) Twin Falls

15. Filed 9-1-1929 David Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/10, 1929, to 8/15, 1929
that I last saw him alive on 8/15, 1929
and that death occurred, on the date stated above, at 7:50 P. m.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia bilateral
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Staphlococcic irido-cyclitis rt. eye (duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? home
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? History, course + P.M.
(Signed) George C. Halley M. D.
Aug 16, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: 8-19 1929

20. Undertaker: White Mortuary
Address: Twin Falls Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67457

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

CERTIFICATE OF DEATH

Registration District No. 37
Primary Registration District No. 1085
(No. County General Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

2. FULL NAME John F. Hansen

(a) Residence. No. 223 Fourth Ave. East St. 129
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) March 20, 1854

7 AGE: Years 75, Months 4, Days 26
If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Denmark

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant J. E. Hayes
(Address) 915 No. Shoshone

15 Filed 8-15, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 13th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 3-5, 1929, to Aug 13th, 1929, that I last saw him alive on Aug 13, 1929, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic Interstitial (Acute Exacerbation (Uremia)
(duration) 5 yrs. ____ mos. ____ ds

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 5 yrs. ____ mos. ____ ds

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory (Blood Chemistry
(Signed) [signature]
8-14, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rock Creek
Date of Burial: Aug 15 1929

20. Undertaker: P. J. Grossman
Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67458

1. PLACE OF DEATH
County of Twin Falls Registration District No. 37
City of Twin Falls Primary Registration District No. 1037
(No. .....)
Local Registrar's No. .....
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Lewis Elbert Achenbach

(a) Residence. No. 1245 East Hyborn St. 31
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1878

7 AGE 51 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of Industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Neb.

PARENTS
10 NAME OF FATHER Lewis Achenbach
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Conlee
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ill

14 Informant E. G. Read
(Address) Salt Lake City Ut.

15 Filed 8-13, 1929 David N. Cowsill, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug, 9th, 29
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 9th, 19 24, to Aug-9th, 19 29
that I last saw h... alive on July 9th, 19 29
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuber
culosis
(duration) 5 yrs. ... mos. ... ds.
CONTRIBUTORY .....
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical Symptoms
(Signed) J. W. Gallagher, M. D.
8-10, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Twin Falls Idaho	Aug 10
20. Undertaker P. J. Grossman	Address

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED AUG 14 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 67459
Registered No.

1. PLACE OF DEATH

County of Valley

City of Yellow Pine

Registration District No.

Primary Registration District No. 15

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob Camp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word.)
Male	White	Single

6. DATE OF BIRTH Unknown 1 (Month) (Day) (Year)

7. AGE About 71 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mark J. Campbell

(Address) .....

15. Filed ..... 19 .....

Stella Cann
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 22 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1929 to June 22 1929 that I last saw h~~im~~ alive on June 14 1929 and that death occurred on the date stated above, at 9:00 M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 5 Yrs. 0 mos. 0 ds.

Contributory (Secondary) Cardiac asthma

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) Duncan C. Ward M. D.

6/7 1929 (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Yellow Pine Ida — DATE OF BURIAL June 25 1929

20. UNDERTAKER Wm M Bradley — ADDRESS Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25-M-1-19

RECEIVED AUG 14 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley

City of McCall

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. ..... St.)

File No. 67460

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Arretta Latham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 14 (Day) 1883 (Year)

7. AGE: 45 Yrs. 1 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Deseret Utah

10. NAME OF FATHER: Isac Alldredge

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ira Latham

(Address) McCall, Idaho

15. Filed ..... 19 .....

Stella Cain
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 90 July (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1928, to July 9 19..., that I last saw her alive on July 9 19..., and that death occurred on the date stated above, at 12 ...

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease following Bright's

(Duration) 3 Yrs. — mos. ..... ds.

Contributory (Secondary) Dropsy

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

..... 19 ..... (Address) McCall Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCall Idaho

DATE OF BURIAL: July 11 1929

20. UNDERTAKER: Wm McBratney A.D.R.

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

RECEIVED AUG 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67461

PLACE OF DEATH
County of Valley
City of Donnelly

Registration District No.
Primary Registration District No. 15
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Emilee Jasper

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 8- 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
			14	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Donnelly - Idaho

PARENTS

10. NAME OF FATHER John Jasper
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rosebery Idaho
12. MAIDEN NAME OF MOTHER Estele Ward
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Donnelly Idaho.

14. Informant John Jasper.
(Address) Donnelly Idaho

15. Filed , 19 . Stella Cain, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 22 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1929, to July 22 1929
that I last saw her alive on July 22, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
6½ month child premature

(duration) yrs. mos. ds.
CONTRIBUTORY ✓
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Dallas Craft M. D.
, 19 (Address) McCall.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED AUG 14 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley

City of McCall

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 15

(No. , St.)

File No. 67462

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cetirus LeRoy Park 913

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 13 (Day) 1858 (Year)

7. AGE: 71 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Timber Inspector

(b) General nature of industry, business or establishment in which employed (or employer): Union Pacific R.R. Co

9. BIRTHPLACE (State or Country): ~~Medina~~ Lodi Ohio

10. NAME OF FATHER: John Park

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Fany Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. L. Park

(Address)

15. Filed 19

Stella Cline
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1929 to July 3 1929 that I last saw him alive on July 3 1929 and that death occurred on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(Duration) Yrs. mos. ds.

Contributory (Secondary): Cardiac insufficiency

(Duration) yrs. mos. 3 ds.

(Signed) Dr U S Craffer M. D.

19 (Address) McCall

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Near Chicago Ill

DATE OF BURIAL 19

20. UNDERTAKER: Wm McBratney

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67464

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
Local Registrar's No. 7
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry P Kizer
(a) Residence. No. West 2 & Pook St St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE Whr
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Phila Kizer
6. DATE OF BIRTH (month, day and year) Jan, 18 - 1858
7. AGE Years 71 Months 6 Days 11 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Mrs H. P. Kizer
(Address) Weiser, Idaho
15. Filed July 30th, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 29 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to July 24, 1929
that I last saw him alive on July 24, 1929
and that death occurred, on the date stated above, at 8.30 m.
The CAUSE OF DEATH* was as follows:
Cardiac Embolism
10 min
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) W. H. Marshall, M. D.
July 30, 1929 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial July 30 1929
20. Undertaker L. C. Northam — Address Weiser Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67465

Registration District No. 5
Primary Registration District No. 1111
Local Registrar's No. 6

PLACE OF DEATH
County of Washington
City of Weiser

(No. 74a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oliver J. Thorne

(a) Residence. No. Weiser Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Nannie M. Thorne

6. DATE OF BIRTH (month, day and year) Feb. 24-1859

7. AGE Years	Months	Days	If LESS than 1 day,
70	5	2	...hrs. or ...min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Telegraph Operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER John Arthur J. Thorne
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN ~~NAME~~ OF MOTHER Margarett Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Nannie M Thorne
(Address) Weiser Ida

15. Filed Jul 27, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 –, 1929, to July 26, 1929
that I last saw him alive on July 16, 1929
and that death occurred, on the date stated above, at 6 8 m.

The CAUSE OF DEATH* was as follows:
apoplexy

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) senility

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) F. A. Schmidt, M. D.
July 27, 1929 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Medvale Ida	7-28 1929
20. Undertaker L. C. Northam	Address Weiser Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67466

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010

Local Registrar's No. 5

(No.) 92
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Miss Laura F. Mohr

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1851

7. AGE Years	Months	Days	If LESS than 1 day,
78	—	—	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER John Mohr
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. New York
12. MAIDEN NAME OF MOTHER Mary Bishop
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14. Informant Fred H. Brubaker
(Address) Emmett - Idaho

15. Filed July 24, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1929, to July 23, 1929
that I last saw her alive on July 23, 19
and that death occurred, on the date stated above, at 10:30 P.m.

The CAUSE OF DEATH* was as follows:
Embolism of mantric artery - With thrombosis of aorta fine
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Shock & senility.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? yes
What test confirmed diagnosis? autopsy
(Signed) F. A. Schmitz, M. D.
July 24, 1929 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Oregon City. Or	
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67467

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86.
Primary Registration District No. 2112
Local Registrar's No. 4

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

160

2. FULL NAME Beverly June Deakins
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word):
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) July 2 - 1929
7. AGE Years — Months — Days 15. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Weiser.

PARENTS
10. NAME OF FATHER Charles W. Deakins.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jordan Valley Oregon.
12. MAIDEN NAME OF MOTHER Esther Woods.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Boise Ida

14. Informant Chas W. Deakins
(Address) Midvale. Ida
15. Filed July 17th, 1929 N. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 17 - 1929 (Month) (Day) 19 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to July 17, 1929 that I last saw her alive on July 17, 1929 and that death occurred, on the date stated above, at 12:10 P m.
The CAUSE OF DEATH* was as follows:
Icterus Neonatorum
(duration) ..... yrs. ..... mos. 15 ds.
CONTRIBUTORY (Secondary) Umbilical Hemorrhage
(duration) ..... yrs. ..... mos. 2 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Ernest O. Finney, M. D.
July 18, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Midvale. Date of Burial: July 18 1929
20. Undertaker: Northam Address: Weiser.

RECEIVED AUG 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67468

Registration District No. 46
Primary Registration District No. 2112.
Local Registrar's No. 3

PLACE OF DEATH
County of Washington
City of Weiser
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John A. Nygaard
(a) Residence No. Cambridge, Idaho St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

10/10

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Wh.
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Hannah Nygaard

6. DATE OF BIRTH (month, day and year): Oct [illegible] 1841

7. AGE: Years 87 | Months 9 | Days 1 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweeden

PARENTS

10. NAME OF FATHER: Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweeden
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Mrs Hannah Nygaard
(Address) Cambridge, Idaho

15. Filed July 15th, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1929, to July 14, 1929
that I last saw him alive on July 14, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
~~July 14~~ (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. F. Hunt M. D.
July 14, 1929 (Address) Cambridge

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salt Lake Utah — Date of Burial: 7-17-1929
20. Undertaker: L. G. Northam — Address: Weiser Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67469

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1018
(No. Lettie Flower Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

44

2. FULL NAME Danforth Wm Hemingway

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 23-1858

7. AGE Years 70 Months 9 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Centerville
(State or country) Utah

PARENTS

10. NAME OF FATHER Jonathan Hemingway
11. BIRTHPLACE OF FATHER (city or town) Vermont
(State or Country)
12. MAIDEN NAME OF MOTHER Joanna Ward Brown
13. BIRTHPLACE OF MOTHER (city or town) Adams
(State or Country) Ohio

14. Informant J. B. Hemingway
(Address) Weiser Idaho

15. Filed July 13, 1929 E. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25, 1929, to July 13, 1929
that I last saw him alive on July 7, 1929
and that death occurred, on the date stated above, at 6 8 m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Hypertrophy of Prostate
..... (duration) ..... yrs. 4 mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) F. A. Schmid, M. D.
July 13, 1929 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery
Date of Burial July 16 1929

20. Undertaker L. C. Northam
Address Weiser Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 20 1929

PLACE OF DEATH

County of Washington

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1010

(No. .....)
(If death occurred in a hospital or institution give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67470

Local Registrar's No. 1

205-a

2. FULL NAME William T Campbell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE Wht

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Laura Campbell

6. DATE OF BIRTH (month, day and year) 1856

7. AGE 73 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work T

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Don Campbell

(Address) Arco, Idaho

15. Filed July 6th, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 5th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5th, 1924, to ....., 19..., that I last saw him alive on July 5th, 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Internal Abdominal Injuries.
Automobile Accident
on hiway outside of town. (duration) 2 or 3 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. R. Hamilton, M. D.

July 6th, 1929 (Address) Weiser Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery | Date of Burial 7-8-1929

20. Undertaker L. C. Northam | Address Weiser Id

RECEIVED JUL 2 1 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Sept. 24, 1929

W.R. Hamilton 67470

Weiser, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

William T. Campbell who died July 5, 1929 at Weiser, Idaho

Cause of death given as "Internal Abdominal Injuries".
Information DESIRED in order to complete certificate.

What kind of an accident was the cause of these injuries. If an automobile accident please state whether the accident was in the city limits or on the highway.
PLEASE ANSWER BELOW

Automobile accident on highway outside of town

W. R. Hamilton M.D.

RECEIVED NOV 7 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

67470

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Dr. W.R. Hamilton

Weiser, Idaho
Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

William T. Campbell who died July 5, 1929 at Weiser, Idaho.
Cause of death given as "Internal abdominal Injuries".

Information DESIRED in order to complete certificate.

Were these injuries caused by an automobile accident? Yes.
If not, what was the cause?

PLEASE ANSWER BELOW

W. R. Hamilton M.D.

5.25
3
7.7

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED AUG 21 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington
City of Cambridge
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....

File No. 67471
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nancie Jane Titus

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Male~~ Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widdow

6. DATE OF BIRTH. March (Month) 25 (Day) 1845 (Year)

7. AGE: 84 Yrs. ~~11~~ Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): ~~Ohio~~ Iowa

10. NAME OF FATHER: John Shuck

11. BIRTHPLACE OF FATHER (State or Country): Pennsalvania

12. MAIDEN NAME OF MOTHER: Nansie Jane Trusler

13. BIRTHPLACE OF MOTHER (State or Country): Pennsalvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John W. Titus
(Address) .....

15. Filed 8-20-29 191.... Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1929, to April 21 1929, that I last saw her alive on April 21 1929, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Exhaustion

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Rheumatism

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G. F. Hunt M. D.

19.... (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge — DATE OF BURIAL: April 23 1929

20. UNDERTAKER: J. A. Anderson — ADDRESS: Cambridge

FORM V. RECEIVED AUG 21 1929 CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Washington Registration District No. .....

County of ..... Primary Registration District No. .....

City of Cambridge (No. ....., ... St.)

File No. 67472

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Elsworth Lough

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. # Widdower (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE 64 .....Yrs.....Mos.....ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indianna

10. NAME OF FATHER Levi Lough

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Loren Lough

(Address) Cambridge Idaho

15. Filed 8-20-29 191 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 14 129 1929

..... (Month) ..... (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19 1929, to Feb. 9 1929 that I last saw him alive on Feb. 9 1929 and that death occured on the date stated above, at ..... M

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... d

(Signed) G. F. Hunt M.D. M.D.

..... 19 ..... (Address) Cambridge.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Cambridge Ida

DATE OF BURIAL 3/16 1929

20. UNDERTAKER J A Hudson

ADDRESS Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 21 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

67474

DO NOT WRITE IN THIS SPACE

State File No. 67474

Registration District No. 28

Primary Registration District No. 2141

Local Registrar's No. 5638

(No. 836 E. Centre St.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace May Carter

(a) Residence. No. 836 E. Centre St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 10, 1878

7. AGE 51 Years | Months 2 | Days 16 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nebraska

PARENTS

10. NAME OF FATHER: Geo. H. Newton

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Sarah Wild

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pensylvania

14. Informant: Rutherford Carter

(Address) Pocatello, Idaho

15. Filed Aug 26, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 26 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Aug 25, 1929 that I last saw her alive on Aug 15, 1929 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows: Drowned in Bath Tub.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M.D.

Aug 26, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Ida. | Date of Burial: Aug 28 1929

20. Undertaker: McHan Undt Co | Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 21 1929

67475

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67475

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2141

Local Registrar's No. 5637

(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John H. Craig

(a) Residence. No. Bungalow Apts. Bridger Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

68 B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 5, 1879.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
49	9	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Coach Shop

(c) Name of employer: O.S.L.R.R.

9. BIRTHPLACE (city or town) (State or country): Nebraska

PARENTS

10. NAME OF FATHER: Joseph I. Craig

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs. Georgina Mc.Nulty
(Address) Los Angeles, California.

15. Filed 8/29, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 25, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocarditis
diagnosed by Dr. C.P. Groom
4 days before death.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur W. Hall Coroner ~~M.D.~~

8/28, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery

Date of Burial: 8/29/29, 19

20. Undertaker: Arthur W. Hall

Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

67476

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67476

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 1000 Block Buchanan)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5650

2. FULL NAME Joshua Fremont Moffitt

(a) Residence. No. 633 N Grant St St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 13th 1858

7. AGE Years 70 Months 10 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Grocerynon
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER J Moffitt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Bessie Newton
(Address) Pocatello Ida

15. Filed 9-11, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from under my care off & on for about 2 years, 19..., to ..., that I last saw him alive on Sept 7th, 1929 and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:
Myocarditis & cardiac dilatation with decompensation -

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? History & Physical Exam.
(Signed) H. A. Castle, M. D.
Sep 9th, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mt View
Date of Burial: 9-9 1929

20. Undertaker: Schumacher & Beasley
Address: Pocatello

RECEIVED SEP 22 1929

67477

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67477

Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. .....

PLACE OF DEATH
County of Adams
City of Cuprum
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.) 196

2. FULL NAME Thos. J. Reinhart

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): M

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) .....

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant L. J. Stephens
(Address) Cuprum

15. Filed 9/29, 1929 M. M. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows: Premature shot in mining No other present, found dead
..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) ....., M. D.
....., 19... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Portland	
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

67478

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67478

PLACE OF DEATH
County of Boise
City of Boise 22 mi. E.

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 246

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Adelia Rea

(a) Residence. No. Barber Idaho St. 188 e
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Paul M. Rea

6. DATE OF BIRTH (month, day and year) Sept. 4 1907

7. AGE Years 22 Months — Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Horse Shoe Bend Ida

PARENTS
10. NAME OF FATHER Arthur Lincoln Sayo
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jasper Co.
12. MAIDEN NAME OF MOTHER Amelia McAskill
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Eureka Nev.

14. Informant Mrs. Emma Finch
(Address) Barber Ida

15. Filed 9-30 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That ~~I attended~~ deceased ~~from~~ was found dead on ..... 19..... ~~that I last saw h~~ ..... alive on ..... 19..... and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Arrow Rock Sept. 23-1929
Killed by Accident Auto going over Grade.
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. A. Schlosser Coroner, ~~M.D.~~
Sept 23, 1929 (Address) Idaho City Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery — Date of Burial 9/25 1929

20. Undertaker Schreeber & McCann — Address Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

67479

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 8

DO NOT WRITE IN THIS SPACE
State File No. 67479

Registration District No. ____
Primary Registration District No. 2002
Local Registrar's No. 74

PLACE OF DEATH
County of Ada
City of Boise
(No. ____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Benjamin Haggett 90
(a) Residence. No. 7 Miles NW of Boise St.
(Usual place of abode)
Length of residence in city or town where death occurred. 9 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a. If married, widowed or divorced
HUSBAND of (or) WIFE of Isabella B. Haggett,

6. DATE OF BIRTH (month, day and year) Aug 4 1848,

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	81	1	8.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer ____

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER Isaac Haggett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Margaret McMillan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs George B Haggett
(Address) Rt 4 Box 2. Boise Idaho

15. Filed 9-18, 19__ W. H. Rhodes Registrar
R. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1924, to Sept 17, 1929
that I last saw h. in alive on Sept 16, 1929
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease
(duration) 5 yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) ____
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? ____
(Signed) A R Bozorth M. D.
Sept 16, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Sept 19 1929
20. Undertaker	Address
Summers & Krebs	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

67480

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67480

PLACE OF DEATH
County of Nezperce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Louis Alexander Bruner

129

(a) Residence. No. Asotin, Wash. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE W White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Zeralda Jane Harding

6. DATE OF BIRTH (month, day and year) Sept. 27 1848

7. AGE

Years	Months	Days	If LESS than 1 day,
80	10	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Logan. county Ohio.

PARENTS

10. NAME OF FATHER John Bruner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Hanna Hall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indianna

14. Informant Mrs L.A. Brumer.
(Address) Asotin, Wash.

15. Filed Aug 25, 1929 Susan E Brum Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-13-29, 19__, to 7-16-29, 19__
that I last saw him alive on 7-16-29, 19__
and that death occurred, on the date stated above, at 1120 A m.
The CAUSE OF DEATH* was as follows: Chronic nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 7-15-29
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) H. P. Rouse M. D.
7-19-29, 19__ (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston, Ida. Date of Burial 7/21/29 19

20. Undertaker H.R. Merchant Address Clarkston Wn.

RECEIVED SEP 28 1929

67481

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67481

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No 2150
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 150

2. FULL NAME George L. Jones

74a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Geraldine Jones

6. DATE OF BIRTH (month, day and year) May 18- 1886

7. AGE Years 43 Months 3 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Elk Creek, Neb.

PARENTS

10. NAME OF FATHER William D. Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER ?- Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs G. Jones
(Address) Idaho Falls, Idaho

15. Filed Aug. 23, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 21 - 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) B.J. Allen -Coroner, ~~M. D.~~
....., 19..... (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Elk Creek, Neb. Date of Burial: Aug. 26/29 19

20. Undertaker: V.F. McHan - Idaho Falls, Address: Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PLACEMENT should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

67482

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67482

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 260
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nolan Sylvester, Woolsey 100a
(a) Residence. No. 1619 N. 26. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice M. Woolsey

6. DATE OF BIRTH (month, day and year): Aug 14 - 1899

7. AGE: 30 Years | Months: 1 | Days: 20. | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laundryman
(b) General nature of industry, business, or establishment in which employed (or employer): Employed by Troy
(c) Name of employer: Laundry

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS
10. NAME OF FATHER: Richard Woolsey
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Christian Saunders
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Mrs. Alice M. Woolsey
(Address) 1619 N. 26 St Boise Idaho

15. Filed 10-5, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 23, 1929, to Oct 4, 1929
that I last saw him alive on Oct 4, 1929
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Perforated Duodenal Ulcer & Broncho Pneumonia
(duration) yrs. mos. 11 ds.
CONTRIBUTORY (Secondary): Hemorrhage
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? Yes Date of Sep 23 1929
Was there an autopsy? No (By Dr J L Stewart)
What test confirmed diagnosis? Operation
(Signed) T. M. Braxton, M. D.
Oct 4, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: Oct 6 1929

20. Undertaker: Summers & Krebs | Address: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

10 B 67483

DO NOT WRITE IN THIS SPACE
State File No. 67483

PLACE OF DEATH

County of Minidoka
City of Heyburn

CERTIFICATE OF DEATH

Registration District No. 19
Primary Registration District No. 2015
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 46

2. FULL NAME Ray T Moon

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of La Priel Moon
April 6 1896

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 33 | Months 6 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Mexico

PARENTS

10 NAME OF FATHER: John T. Moon
11 BIRTHPLACE OF FATHER (city or town) (State or country): Mexico
12 MAIDEN NAME OF MOTHER: Harriett Weifaur
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Utah

14 Informant: La Priel Moon
(Address): Heyburn Idaho

15 Filed Sept 30, 1929 Ed Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 20 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1929, to Sept 20, 1929, that I last saw him alive on Sept 20, 1929, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows: Mesenteric Thrombosis (Superior Mesenteric Artery with osmosis of blood serum and paralysis of about 24 ins. small intestine) (duration) 1 mos. 2 ds.

CONTRIBUTORY (Secondary) ..... (Ett E)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Sept 20
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E Dean, M. D
Sept 28, 1929 (Address) Burley Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Heyburn Cemetry
Date of Burial: Sept 23 192
20 Undertaker: W. A. Goodman Rupert Idaho
Address

67484

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67484

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 72

(No. U. S. Veterans' Bureau, Boise, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Domingo V. Laca

(a) Residence. No. Lovelock, Nevada St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

31

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6. DATE OF BIRTH (month, day and year): 4-5-1897

7. AGE: Years 32, Months 5, Days xx. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Spain

PARENTS

10. NAME OF FATHER: xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country): xx

12. MAIDEN NAME OF MOTHER: xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): xx

14. Informant M. Cornelius
(Address) U. S. Vet. Bureau, Boise, Idaho

15. Filed 9-7, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1928, to Sept. 5, 1929
that I last saw him alive on Sept. 5, 1929
and that death occurred, on the date stated above, at 8:10 P. m.
The CAUSE OF DEATH* was as follows:

Tbc. pul. chr., act. far advanced C.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? xx

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Laboratory

(Signed) F. C. Smith M. D.
F. C. Smith, Regional Medical Officer
(Address) U. S. Vet. Bureau
Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. John's Cemetery
Date of Burial: 9/9/29

20. Undertaker: Wm. McBratney
Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

67485

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67485

PLACE OF DEATH

County of FREMONT

City of ASHTON

CERTIFICATE OF DEATH

Registration District No. 102

Primary Registration District No. 6

(No. .....)

Local Registrar's No. .....

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME ROBERT RUE MURDOCH

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX MALE

4 COLOR OR RACE WHITE

5 Single, Married, Widowed, or Divorced (write the word) MARRIED

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) NOVEMBER 16th 1892

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
36	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work AUTOMOBILE MECHANIC

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer HUMES & SWANSTRUM.

9 BIRTHPLACE (city or town) (State or country) HEBER CITY UTAH

PARENTS

10 NAME OF FATHER BRIGHAM MURDOCH

11 BIRTHPLACE OF FATHER (city or town) (State or country) HEBER CITY UTAH

12 MAIDEN NAME OF MOTHER MARY BLANCHE ALEXANDER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) UTAH

14 Informant BRIGHAM MURDOCH

(Address)

15 Filed 10-11, 1929 C.A. Meacham
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9/19/29
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: ACCIDENTAL DEATH FROM AUTO ACCIDENT

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? EXAMINATION

(Signed) C.A. Meacham, M. D.

10-11, 1929 (Address) Ashton, Ida.

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal HEBER CITY UTAH

Date of Burial 9/23/29

20. Undertaker LEWIS KISER ASHTON IDAHO

Address

LEWIS KISER

CUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 7 1929

67486

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67486

PLACE OF DEATH

County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No. 113 N. Jefferson St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 45

2. FULL NAME Alice Virginia Everton

(a) Residence. No. ..... St. 164
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin Everton

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 79 | Months | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Balston Spa
(State or country) New York

PARENTS

10. NAME OF FATHER Geo. Hall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.
12. MAIDEN NAME OF MOTHER Emily Blood
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant Mrs. J.A. Harding
(Address) Ponca, Neb.

15. Filed Oct 2, 1929 W H Carithers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Sept 26, 1929
that I last saw her alive on Sept 26, 1929
and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:
Old age infirmity with some form of intestinal trouble causing bloating
(duration) yrs. 5 mos. ds.
nervous shock from house burning next door

CONTRIBUTORY (Secondary)
(duration) 18 hours yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? General appearances
(Signed) F. M. Leitch, M. D.
Sept 28, 1929 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow
Date of Burial: 9/30/29 19

20. Undertaker: H. R. Short
Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67487

PLACE OF DEATH
County of Adams
City of Cuprum

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Carl Renstrum

(a) Residence. No. St. 196
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant G. J. Stephens
(Address) Cuprum

15. Filed 9/19, 1929. W. M. Boone
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Premature shot in mine. No other present. Found dead
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Portland
Date of Burial 19

20. Undertaker
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67488

PLACE OF DEATH

County of Bannock
City of Near Grace, Ida.

CERTIFICATE OF DEATH

Registration District No. 84
Primary Registration District No. 2161
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 163

2. FULL NAME Dale Barton Smith

(a) Residence. No. ..... St. 162
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 0 Months 0 Days 6 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None - Infant
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Near Grace, Idaho

PARENTS
10 NAME OF FATHER: E. Parley Smith
11 BIRTHPLACE OF FATHER (city or town) (State or country): (near) Grace, Ida.
12 MAIDEN NAME OF MOTHER: Lillie Barton
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kaysville Utah

14 Informant: E. Parley Smith
(Address): Grace, Idaho

15 Filed 6/11, 1929 Mrs. G. G. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 11 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1929, to June 11, 1929, that I last saw him alive on June 7, 1929, and that death occurred, on the date stated above, at 11:20 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Emphysema

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary): Asphyxia Neonatorum

..... (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex

(Signed) Russell Figert, M. D.

6/11, 1929 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of ~~Burial~~, ~~Cremation~~, or Removal: Kaysville, Utah
Date of Burial: 6/12 1929

20. Undertaker
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67489

PLACE OF DEATH

County of Bannock

City of Lava Hot Springs

Registration District No. 28

Primary Registration District No. 2161

(No. Lava Hot Springs)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5639

2. FULL NAME Jacob Stotz

179

(a) Residence. No. Nampa, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE: About Years 89 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: ~~XXXXX~~ Andrew Hooper

(Address) Lava Hot Springs.

15. Filed 8/23, 1929. J. M. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 21, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Third degree burns scolded in Hot pool (accidental) Fat degeneration of Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? ~~Arthur W. Hall~~

(Signed) Arthur W. Hall, coroner ~~M. D.~~

9-21, 1929 (Address) Pocatello.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa, Idaho.

Date of Burial: On Arrival 19

20. Undertaker: Arthur W. Hall

Address: Pocatello.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67490

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 461
(No. Lym Bros Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5640

2. FULL NAME Geo. Griffiths

(a) Residence. No. no city St. 201
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6. DATE OF BIRTH (month, day and year) Feb. 19, 1852

7. AGE 77 Years 6 Months 5 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER S. R. Griffith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pensylvania
12. MAIDEN NAME OF MOTHER Mary J. Newell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Ellen Griffiths
(Address) Pocatello Ida

15. Filed Aug 23, 1929. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22, 1929, to Aug 23, 1929
that I last saw him alive on Aug 23, 1929
and that death occurred, on the date stated above, at 1:45 a m.
The CAUSE OF DEATH* was as follows: Fractured Skull. Double Fracture of left leg (shoe) Result of auto accident in front of his home on Yellowstone Hiway - unavoidable accident - coroner's jury verdict
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Age (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Exam
(Signed) J. H. Young M. D.
8/23/29 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pocatello Ida
Date of Burial Aug 25 1929

20. Undertaker McHan Undt Co
Address Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67490

Dr. J.H. Lynn
Pocatello

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Geo. Griffiths who ~~MAX~~ died Aug. 23, 1929
Cause of death given as "Fractured skull. Double Fracture of left leg.(shock)"

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH? IF AN AUTO WAS INVOLVED PLEASE NAME THE PLACE WHERE THE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW: Pocatello, Idaho. Feb. 26. 1930

Dear Sir.

Yes, it was the result of an Auto accident directoy in front of his own home about three miles north of this City. on the Yellowstone Highway. Coroners jury found it an unavoidable accident.

Yours Truly.

J. W. Lynn

NOV 12 1963
JAN 18 1963

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67491

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5641
(No. St Anthony's Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gertrude J. Hinckley
(a) Residence. No. 322 So. 3rd St. 73
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Nov 24-1900
7. AGE Years 28 Months 9 Days — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS
10. NAME OF FATHER L. A. Lamont.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Mattie Howe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Alton Hinckley
(Address) Pocatello Idaho
15. Filed Aug 24 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 24 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 21, 1929, to Aug 24, 1929
that I last saw her alive on Aug 24, 1929
and that death occurred, on the date stated above, at 1.45 a m.
The CAUSE OF DEATH* was as follows:
Cerebral Anemia
Post Operative
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Hysterectomy and Ovarian cyst.
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? Yes Date of Aug 21, 1929
Was there an autopsy? Yes
What test confirmed diagnosis? Physical, Post, symptom
(Signed) O. F. Ead M. D.
Aug 24, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls Ida. Date of Burial Aug 25 1929
20. Undertaker McHan & Lt. Co. Address Pocatello

RECEIVED FEB 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67491

Dr. O.F. Call
Pocatello, Ida.

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Gertrude J. Hinckley who died Aug. 24, 1929
Cause of death given as "Cerebral Anemia. Post Operative."

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Hysterectomy and Ovarian cyst.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67492

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5642
(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louis Veras
(a) Residence. No. 144 N. 4th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

188 e

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Mar 24 1892
7. AGE 37 Years Months 5 Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Greece

PARENTS
10. NAME OF FATHER Veras
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Greece
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs L. Veras
(Address) Pocatello

15. Filed 8/24, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8/24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/23, 1929, to 8/24, 1929
that I last saw him alive on 8/24, 1929
and that death occurred, on the date stated above, at 8 a m
The CAUSE OF DEATH* was as follows:
Skull Fracture —
(duration) yrs. mos. ds
CONTRIBUTORY (Secondary) Auto accident in city of Pocatello —
(duration) yrs. mos. ds

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy finding
(Signed) J. Young
8/24, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View
Date of Burial 8/26 1929
20. Undertaker Schumacher & Beasley
Address City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67493

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2461

Local Registrar's No. 5643

(No. General Hospitol.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henrettia C. Call.

(a) Residence. No. Chesterfield, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Heber~~ Sidney B. Call.

6. DATE OF BIRTH (month, day and year) Oct. 23. 1869.

7. AGE: 59 Years, 9 Months, 3 Days. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Centerfield, Utah.

PARENTS

10. NAME OF FATHER Heber C. Loveland.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Columbia Call.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Fillmore, Utah.

14. Informant Elizabeth C. Butterfield.
(Address) Murray, Utah.

15. Filed 8/27, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 26. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26, 1929, to Aug 26, 1929
that I last saw her alive on Aug 26, 1929
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows: Anesthetic Respiratory Paralysis - operation for Procidentia uterus.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Died On Op. Table
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 8/26-1929
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
8/27, 1929 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Chesterfield, Idaho
Date of Burial: On Arrival, 1929

20. Undertaker ~~A. W. H.~~ [signature] Address: Poca, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED FEB 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67493

Dr. O.F.Call
Pocatello

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Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Henrettia C. Call who died Aug. 26, 1929
Cause of death given as "Anesthetic Respiratory Paralysis," Died on operating table.

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Procidentia Uterus.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67495

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 636 N. Main)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5645

2. FULL NAME Gertrude Ansola 46

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Ansola

6. DATE OF BIRTH (month, day and year): May 18 - 1885

7. AGE: Years 44, Months 3, Days 4. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Trained
(b) General nature of industry, business, or establishment in which employed (or employer): Nurse
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Washington D. C.

PARENTS

10. NAME OF FATHER: William Gates
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Washington D. C.
12. MAIDEN NAME OF MOTHER: Mercier Crawley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Washington D. C.

14. Informant: Joseph Ansola
(Address): Pocatello Idaho

15. Filed 8/28, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 22 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1928, to Aug 22, 1929
that I last saw her alive on Aug 22, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Carcinoma of cervix uteri
..... (duration) 5 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Operation Hysterectomy
2 yrs ago (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Aug 1927
Was there an autopsy? No
What test confirmed diagnosis? Path report
(Signed) [signature], M. D.
8-27, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: Aug 24 1929

20. Undertaker: Schumacher & Beasley — Address: Cty

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67496

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. 1319 S. 5 St.)
Local Registrar's No. 5646

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Juanita Minnie Smith

(a) Residence. No. 1319 S. 5 St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 6th, 1923

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
6	2	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

PARENTS

10. NAME OF FATHER Alfred Smith
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Juice Creek
12. MAIDEN NAME OF MOTHER Ellen Josephine Ennis
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Oswego Ida

14. Informant Alfred Smith
(Address) Pocatello Ida

15. Filed 8-28, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Crushed Skull
(accidental) Killed while
playing on side of Hill.
Fell from Cliff (duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Arthur W Hall Coroner M. D.
8/28, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View	Aug 29 1929
20. Undertaker	Address
Schumacher & Beasley	City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67497

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5647
(No. 906 So. 2nd ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John T. Woolsey 90
(a) Residence No. 906 So. 2nd St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 8, 1883

7. AGE: Years 45, Months 11, Days —, If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: Abraham Woolsey
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Diana Radford
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Celia T. Woolsey
(Address) Pocatello Idaho

15. Filed 9-9, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 5, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1927, to Sept 5, 1929
that I last saw him alive on Sept 5, 1929
and that death occurred, on the date stated above, at 11 20 P. m.
The CAUSE OF DEATH* was as follows:
Organic heart - (Mitral leak)
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F. S. Miller M. D.
9/9, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kirie, Idaho — Date of Burial: Sept 9, 1929

20. Undertaker: McHan Undt. Co. — Address: Pocatello

RECEIVED SEP 25 1929

Dr Howard

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67498

Registration District No. 28
Primary Registration District No. 241
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5648

PLACE OF DEATH
County of Bonneck
City of Pocatello

2. FULL NAME Peter anders

(a) Residence. No. 643 N 5th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 28-1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	4	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello

PARENTS

10. NAME OF FATHER Jim Anders.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Greece
12. MAIDEN NAME OF MOTHER Mary Spirapoles
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Greece

14. Informant Jim Anders
(Address) Pocatello Idaho

15. Filed 9-15, 1929. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 11 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9, 1929, to Sept 11, 1929
that I last saw him alive on Sept 10, 1929
and that death occurred, on the date stated above, at 4a m.
The CAUSE OF DEATH* was as follows:
Cerebro-spinal meningitis epidemic type
(duration) yrs. mos. 15 ds.
CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical and microscopic
(Signed) William D. Howard M. D.
9/11, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	9-11 1929
20. Undertaker	**Address**
Schumacher & Beasley	City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67499

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 261
Local Registrar's No. 5649
(No. 829 N. Garfield)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Downey 90
(a) Residence. No. 829 N. Garfield St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) April 18 - 1850
7. AGE Years 79 Months 4 Days 12 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Washington Indiana

PARENTS
10. NAME OF FATHER Andrew Farrell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Katherine Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14. Informant James C. Downey
(Address) Pocatello Idaho

15. Filed 9-11, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug - 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1929, to Aug 30, 1929
that I last saw her alive on Aug 30, 1929
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
(duration) yrs. 3 mos. — ds.
CONTRIBUTORY (Secondary) old age
(duration) — yrs. ~~mos.~~ — ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? physical findings
(Signed) , M. D.
8-31, 1929 (Address) Mt. Home

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View Date of Burial Sept 2 1929
20. Undertaker Schumacher & Beasley Address City

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

Dr Brothers

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67500

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2166
(No. 222 S. 6 St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5657

2. FULL NAME Mary Francis Matthews 129
(a) Residence. No. 222 S. 6 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 21st 1864

7. AGE: Years 65, Months 3, Days 20. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): South Amboy N. J.

PARENTS
10. NAME OF FATHER: Joe Webb
11. BIRTHPLACE OF FATHER (city or town) (State or Country): London Eng.
12. MAIDEN NAME OF MOTHER: Josephine Murphy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Madrid Spain

14. Informant: Geo W Matthews
(Address) City

15. Filed 9/11, 1929. J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Sept 10, 1929
that I last saw her alive on Sept 9, 1929
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:
Chronic parenchymatous nephritis
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination of urine
(Signed) W W Brothers M. D.
9-11, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View
Date of Burial: Sept 12 1929

20. Undertaker: Schumacher & Beasley
Address: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67501

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 216
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3652

2. FULL NAME Elizabeth J. Lee Corbridge

(a) Residence. No. 522 North Garfield Ave. St. Poca. Ida.
(Usual place of abode)
Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William E. Corbridge

6. DATE OF BIRTH (month, day and year) Jan. 1, 1854.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	8	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Hanover, Conn.

PARENTS

10. NAME OF FATHER: George Lee
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Sarah Peaker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. Bert Nichols
(Address): Pocatello, Idaho.

15. Filed 9-11, 1929. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 9, (Day) 1929. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 9-5, 1929, to 9-9, 1929
that I last saw h[e] alive on 9-8, 1929
and that death occurred, on the date stated above, at 1.45 a.m.
The CAUSE OF DEATH* was as follows:
Cardio-renal disease

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Heart & kidney

(Signed) [signature], M. D.
9/11, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	9/12/29 19

20. Undertaker: Arthur W. Hall — Address: Poca. Ida.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 28

DO NOT WRITE IN THIS SPACE
State File No. 67502

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No.
Primary Registration District No. 2161
Local Registrar's No. 56 B

(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William E. Corbridge

(a) Residence. No. 522 North Garfield Ave. Poca. Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth J. Lee

6. DATE OF BIRTH (month, day and year) July 9, 1847

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	2	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Carpenter
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: William Corbridge
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Ellen Parker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. Bert Nichols
(Address): Pocatello, Idaho.

15. Filed 9-11, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 10, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18th, 1929, to Sept 10th, 1929
that I last saw him alive on Sept. 10th, 1929
and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:
Prostatic Carcinoma
with Complications

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis - Nephritis

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History & Physical Exam

(Signed) W. A. Castle, M. D.
Sept 11th, 1929 (Address) Pocatello, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	9/12/29 19
20. Undertaker: Arthur W. Hall	Address: Pocatello

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67503

Local Registrar's No. 5654

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. General Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Floyd Blain Aldous. 1/24

(a) Residence. No. Downey, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June. 16. 1911.

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	18	2	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Downey,
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Robert F. Aldous.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Utah.

12. MAIDEN NAME OF MOTHER Christina Felt.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Utah.

14. Informant Mr. Robert F. Felt.
(Address) Downey. Idaho.

15. Filed 9-15, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
September. 12. 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-9, 1929, to 9-11, 1929
that I last saw h~~e~~ alive on 9-11, 1929
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
General Peritonitis

(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) Perforated Appendix
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? Downey Ida
Did an operation precede death? Yes Date of 9/9/29
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E. E. Howell, M. D.
9/13, 1929 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Downey, Idaho.	1929.

20. Undertaker A. W. Hall. Address Pocatello, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67504

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5655

PLACE OF DEATH

County of Bannock
City of Pocatello
(No. Lynn Bros. Hospitol.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

72-a

2. FULL NAME Melvin G. Johansen.

(a) Residence. No. 335 No. 6th. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) September. 9. 1929.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Jacob Johansen.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway.
12. MAIDEN NAME OF MOTHER Laura Pearl Mitchell.
13. BIRTHPLACE OF MOTHER (city or town) Amon, (State or Country) Idaho.

14. Informant Mr. Jacob Johansen.
(Address) 335 No. 6th.

15. Filed 9-15, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 12. (Day) 1929. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9, 1929, to Sept 12, 1929
that I last saw h[illegible] alive on Sept 12, 1929
and that death occurred, on the date stated above, at 12 A. m.
The CAUSE OF DEATH* was as follows: Blue Baby

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phy Exam
(Signed) J. H. Lynn, M. D.
9-13, 1929 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cem. Amon Ida.	9-14-1929

20. Undertaker A. M. Hall. Address Pocatello Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67505

CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5656

PLACE OF DEATH

County of Bannock
City of Pocatello
(No. St. Anthony Hospitol.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Evelyn Ward Gustaveson. 13 B

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ex Ernest A. Gustaveson.

6. DATE OF BIRTH (month, day and year) July. 22. 1887

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
44	1	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Beaver City. Utah.

PARENTS

10. NAME OF FATHER Samuel Ward.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Delaware.
12. MAIDEN NAME OF MOTHER Elizabeth Stewart.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant E.A. Gustaveson
(Address) Pocatello

15. Filed 9-15, 1929. J.M. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September. 13. 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to Sept 12, 1929
that I last saw h[illegible] alive on Sept 12, 1929
and that death occurred, on the date stated above, at 1:15 a.m.

The CAUSE OF DEATH* was as follows:
Primary Cerebral Hemorrhage
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Infected decubitus, Cystitis
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Blood exam.
(Signed) Asa Newton, M. D.
Sept 13, 1929 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cem.	1929
20. Undertaker A. L. Hall	Address Pocatello Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67506

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Poc. General Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5657

2. FULL NAME Kathryn Ann Merrill 162

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 15, 29

7. AGE Years — Months — Days — If LESS than 1 day, 14 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS
10. NAME OF FATHER Theo M. Merrill
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.
12. MAIDEN NAME OF MOTHER Kathryn Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montpelier Idaho

14. Informant Theo Merrill
(Address) Pocatello Idaho

15. Filed 9-16, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14, 1929, to Sept 15, 1929
that I last saw h..... alive on ....., 19..
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:
Atalectic Lung
..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Congenital
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Exam
(Signed) O. Neal M. D.
9/16, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Idaho — Date of Burial: Sept 16 1929

20. Undertaker: McHan Undt Co — Address: Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67507

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello Gen Hosp)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5658

46

2. FULL NAME Lottie Lee Brunker

(a) Residence. No. 129 N. Johnson St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 20, 1889

7. AGE Years 39 Months 11 Days 26 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER Robert L. Glenn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Quintie Thomas
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Robert G. Brunker
(Address) Pocatello, Idaho

15. Filed Sept 17, 1929 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-1, 1929, to 9-16, 1929
that I last saw her alive on 9-16, 1929
and that death occurred, on the date stated above, at 7:10 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma uterus
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Carcinoma cervix
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Findings
(Signed) [signature], M. D.
9/16, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Idaho
Date of Burial: Sept 18 1929

20. Undertaker: McHan Undt Co.
Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67508

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

(No. Pocatello Tourist Park)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5659

2. FULL NAME Joseph Edgar Abbey

(a) Residence. No. Miles City, Montana. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

31

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Violet J. Oxford

6. DATE OF BIRTH (month, day and year): Feb. 6, 1904.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
25	7	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Miles City, Montana.

PARENTS

10. NAME OF FATHER: Nathaniel E.W.Abbey

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Emmie Holbrook

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant: Mrs. Edna Abbey Lantis

(Address): Miles City, Montana

15. Filed 9-17, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 14, 1929. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1929, to Sept 13, 1929

that I last saw him alive on Sept 13, 1929

and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows: Pulmonary T.B.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary T.B.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) H. C. Dawson M. D.

9/15, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Miles City, Montana

Date of Burial: On Arrival

20. Undertaker: Arthur W. Hall

Address: Pocatello

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 28

DO NOT WRITE IN THIS SPACE
State File No. 67509

Local Registrar's No. 5660

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No.
Primary Registration District No. 216
(No. St. Anthony Hospital, Poca. Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ~~Infant~~ Dean Rupp

(a) Residence. No. 161a St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 16, 1929.

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	0	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Linial A. Rupp
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City, Utah.
12. MAIDEN NAME OF MOTHER Ethel Fox
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Colorado.

14. Informant Mrs. G. M. Rupp
(Address) Pocatello, Idaho.

15. Filed 9-19, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 18, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16, 1929, to Sept 18, 1929
that I last saw h[illegible] alive on Sept 18, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Premature birth
due to rupture of
bag of waters 3 days
previously. (duration) yrs. mos. 2 ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D. C. Ray, M. D.
9-19, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	9/19/29.

20. Undertaker Arthur W. Hall Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67510

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 561

PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louisa D. Holmes

(a) Residence. No. 176 Wayne Ave. St. Pocatello, Idaho
(Usual place of abode)
Length of residence in city or town where death occurred. 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Holmes

6. DATE OF BIRTH (month, day and year) March 18, 1870.

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	5	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Charles Daich
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Harris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs. Doris Jensen
(Address) 176 Wayne Ave. Pocatello, Idaho.

15. Filed 9-19, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 17, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec, 1927, to Sept 17, 1929
that I last saw her alive on Sept 17, 1929
and that death occurred, on the date stated above, at 1:30 a m.
The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical
(Signed) J. R. Young M. D.
9-17, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	9/20/29. 19
20. Undertaker Arthur W. Hall	Address Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67511

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5662

(No. Pocatello, Gen. Hosp.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME J. Parker Wanamaker

(a) Residence. No. ..... St. 92
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Sept 26, 1876

7. AGE 53 Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Station agent

(b) General nature of industry, business, or establishment in which employed (or employer) O. S. L. R. R. Co.

(c) Name of employer Inkom Ida

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Warren W. Wanamaker

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER Neal Reese

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant E. H. Gibson
(Address) Ashton, Idaho.

15. Filed Sept 20, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-8, 1929, to 9-19, 1929

that I last saw him alive on 9-19, 1929

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Mesenteric thrombosis

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Paralytic ileus

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/13/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

9/20, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Edgertown, Ohio — Date of Burial Sept 22 1929

20. Undertaker McHan Undt Co. — Address Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67512

Registration District No. 28

Primary Registration District No. 241

Local Registrar's No. 5663

(No. Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Catherine Criswell 57

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 26 1861

7. AGE Years 68, Months 7, Days 25, If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wif

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: Robt McComack

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Millie

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: C. F. Criswell
(Address) Pocatello Ida

15. Filed Sept 20, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-1, 1929, to 9-20, 1929

that I last saw her alive on 9-20, 1929

and that death occurred, on the date stated above, at 12,20 p.m.

The CAUSE OF DEATH* was as follows:

Diabetic Cava

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Operation for pain of gangrenous foot & leg. (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 9/17/29

Was there an autopsy? Yes

What test confirmed diagnosis? Blood & urine

(Signed) [signature], M. D.

9/20, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Ida — Date of Burial: Sept 22 1929

20. Undertaker: McHan Undt Co. — Address: Pocatello

RECEIVED MAR 1 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

67512

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Dr. E.N. Roberts
Pocatello, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Catherine Criswell whodied Sept. 20, 1929
Cause of death given as "Diabetic Coma."

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Pain from gangrenous foot and leg.

3/27/30

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67513

PLACE OF DEATH
County of Bannock
City of Cleveland
Registration District No. 8 3
Primary Registration District No. 2160
Local Registrar's No. 113
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Catherine Lucinda Grant

(a) Residence. No. 44 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	Divorsed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Grant

6. DATE OF BIRTH (month, day and year) Nov. 18 1884

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	7	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Thatcher Idaho

PARENTS

10. NAME OF FATHER Nelse Georgensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Carrie Nelsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Edith Oowling
(Address) Echo Utah

15. Filed Sept 15, 1929 Mary C. Coffin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/23, 1929, to 7/24, 1929, that I last saw h[illegible] alive on 7/23, 1929, and that death occurred, on the date stated above, at 3 p. m.,
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) Heart Block.
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? not Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Exam
(Signed) E S Gulford, M. D.
7/25, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cleveland Idaho	July 26 29

20. Undertaker	Address
M. W. Hndricks	Preston Idah

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED SEP 19 1929

1. PLACE OF DEATH — Registration District No. 63
County of Bannock — Primary Registration District No. 2160
City of Downey — (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 6751
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fay Myra Cutright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH — August 10 1929 (Month) (Day) (Year)

7. AGE — ..... Yrs. ..... Mos. 4 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work — Infant
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) — Downey, Idaho

10. NAME OF FATHER — J. W. Cutright

11. BIRTHPLACE OF FATHER (State or Country) — West Virginia

12. MAIDEN NAME OF MOTHER — Nellen Metrichew

13. BIRTHPLACE OF MOTHER (State or Country) — Pitsburg, Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Cutright
(Address) Downey, Idaho

15. Filed Sept 15 1929 — Mary E. Coffin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 204 — Aug - 14 - 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1929, to Aug - 14 - 1929 that I last saw her alive on Aug 10 - 1929, and that death occurred on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:
Sudden death
Congenital Heart Disease.
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Hartigan, M. D.
8-14-1929 (Address) Downey, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — Cambridge Idaho — DATE OF BURIAL Aug 15 1929

20. UNDERTAKER — None — ADDRESS Downey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 19 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Downey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83

Primary Registration District No. 2160

(No. ..... , ... St.)

File No. 67515

Registered No. 115

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cecile Porter Whitaker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Dec (Month) 28 (Day) 1898 (Year)

7. AGE: 30 Yrs. 7 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Porterville Ut.

10. NAME OF FATHER: Alma Porter

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Sarah Jane Carter

13. BIRTHPLACE OF MOTHER (State or Country): Kaysville Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. M. W. Whitaker

(Address) Downey Ida

15. Filed Sept-15- 1929 Mary C. Coffin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 20 (Day) 1929 (Year) 32

17. I HEREBY CERTIFY, That I attended deceased from July-25-1929, to Aug-20-1929 that I last saw her alive on Aug-19-1929 and that death occurred on the date stated above, at 6 30 A M.

The CAUSE OF DEATH* was as follows: Tuberculous Meningitis

(Duration) ..... Yrs. ..... mos. 17 ds.

Contributory (Secondary): Childbirth

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. J. Hastingsen M. D.

Aug 21 1929. (Address) Downey, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Downey Ida

DATE OF BURIAL: Aug 22 1929

20. UNDERTAKER: J. Guy Benson

ADDRESS: Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67516

PLACE OF DEATH
County of Bingham
City of Sterling

Registration District No. 116
Primary Registration District No. 2195
Local Registrar's No. 28

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eugene Dedrick Line

(a) Residence. No. Knoxville Tennessee St. 88 B
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. — yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Hannah Line

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 56 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Morristown, Tenn.

PARENTS
10. NAME OF FATHER: Porter Line
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tennessee
12. MAIDEN NAME OF MOTHER: Elizabeth Bacon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tennessee

14. Informant: Hugh H. Line
(Address) Sterling, Ida

15. Filed Sept 14, 1925 McMerkinnon
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8, 1925, to Sept 12, 1925
that I last saw him alive on Sept 10, 1929
and that death occurred, on the date stated above, at 1 A m.
The CAUSE OF DEATH* was as follows:
Subacute myocarditis
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Cardiac Asthma
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? Tennessee
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? none.
(Signed) M. C. McKinnon, M. D.
Sept 14, 1925 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Blackfoot Idaho | Date of Burial: Sept 15 1929

20. Undertaker: E. T. Peck | Address: Blackfoot Ida

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67517

PLACE OF DEATH
County of Bingham
City of Aberdeen

Registration District No. 116
Primary Registration District No. 2193

Local Registrar's No. 29

(No. 13)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Axum Scott Huls

(a) Residence. No. ..... St. Aberdeen Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Vira Huls

6. DATE OF BIRTH (month, day and year) ~~Dec~~ 3/8/52

7. AGE	Years	Months	Days	If LESS than 1 day,
	76	11		..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Shelbyville Indiana

PARENTS

10. NAME OF FATHER John Axom Huls
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant C. P. Abercrombie
(Address) Aberdeen Ida

15. Filed Sept 28, 1929 M. C. Mackinnon
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to Sept 28, 1929
that I last saw h. in alive on Sept 28, 1929
and that death occurred, on the date stated above, at 10 A., m.

The CAUSE OF DEATH* was as follows:
Subacute Combined Sclerosis of the Spinal Cord

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? None

(Signed) M. C. Mackinnon, M. D.
Sept 28, 1929 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Aberdeen Ida	Sept 29 1929
20. Undertaker Friends	Address

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67519

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 165
(No. SOUTH IDAHO INSANE ASYLUM 31)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME SARAH INEZ GRANT

(a) Residence. No. ..... St. WEISER Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Chas H Grant

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work HOUSEWIFE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER David Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ---
12. MAIDEN NAME OF MOTHER Rosa Valentine ~~XXXXX~~
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salem

14. Informant Grace A Clippinger R.N.
(Address) Blackfoot, Ida.

15. Filed Sept. 14, 1929 McCleave E Caine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 14th, 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20th 1929, 19, to Sept 14 1929, 19
that I last saw her alive on Sept 13th 1929, 19
and that death occurred, on the date stated above, at 5 A m.
The CAUSE OF DEATH* was as follows:

PULMONARY TUBERCULOSIS

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted, if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) G.G. Williams, M. D.
Sept 14th, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Weiser Idaho	19
20. Undertaker	Address
E J Funk	Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67521

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 163

(No. Highway Bridge, South of Blackfoot)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188 e

2. FULL NAME William Phillips

(a) Residence. No. 744 South Hayes Ave. Poca. Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): May 4, 1883.

7. AGE: Years 46, Months 4, Days 11. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Fords Pool Hall

(c) Name of employer: Pocatello, Ida.

9. BIRTHPLACE (city or town) (State or country): Malad, Idaho.

PARENTS

10. NAME OF FATHER: Edward Phillips

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Elizabeth Jones

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Logan, Utah.

14. Informant: Edward Phillips
(Address) 744 South Hayes Ave. Poca. Ida.

15. Filed Sept 15, 1929. Mrs Walter E. Catone, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 15, 1929. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ___, 19___, to ___, 19___

that I last saw h___ alive on ___, 19___

and that death occurred, on the date stated above, at 5;30P.M m.

The CAUSE OF DEATH* was as follows:

Multiple injury to the head, chest, and right arm caused by automoble colliding with bridge abutment on highway.

Fracture of Skull, Hemorrhage, Accidental. Loss of arm,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Eye witnesses.

(Signed) Ray McClellan M. D.

Sep. 15. 29, 19 County Coroner. Bingham County.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View, Poca. Ida. Date of Burial: 9/19/29. 19

20. Undertaker: Arthur W Hall. Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67522

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 162

76

2. FULL NAME GEORGE T TOPHAM

(a) Residence. No. ..... St. IDAHO FALLS
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Adeline Topham

6. DATE OF BIRTH (month, day and year)

7. AGE: 65 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Fremont County Iowa

PARENTS

10. NAME OF FATHER: William Topham-
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Melinda Baldwin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mass.

14. Informant: H. G. Houthin Att.
(Address) Blackfoot

15. Filed: Sept 12, 1929 Mrs Walter E. Catine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 12-1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1927, 19 , to Sept 12 1929, 19
that I last saw him alive on Sept 12 1929, 19
and that death occurred, on the date stated above, at 10:35 A m.
The CAUSE OF DEATH* was as follows:

Paralysis of Insane
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Weak Emaciated
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) G. D. Williams, M. D.
Sept 12th, 1929 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls | Date of Burial: Sept 15 1929

20. Undertaker: Cliff C Hayes | Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67523

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 161

105

2. FULL NAME Margaret Elaine Freckleton
(a) Residence. No. RD# 3 Blackfoot St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year): Sept 18, 1917
7. AGE: Years 11, Months 11, Days 29 (23) If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —
9. BIRTHPLACE (city or town) (State or country): Eureka, Utah

PARENTS
10. NAME OF FATHER: Samuel H. Freckleton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Deseret Utah
12. MAIDEN NAME OF MOTHER: Zilpha V. Cutler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Slatersville Utah

14. Informant: S H Freckleton
(Address) Route 3 Blackfoot

15. Filed Sept 13, 1929 McCalvin E. Catrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 11, 1929 that I last saw her alive on Sept 11, 1929 and that death occurred, on the date stated above, at 11:00 a m.

The CAUSE OF DEATH* was as follows:

Asthma

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Probably enlarged Thymus gland
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W W Beck M. D.
Sept 13, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery
Date of Burial: Sep. 15 1929
20. Undertaker: Ed T Park
Address: Blackfoot

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67524

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 160

2. FULL NAME Wallace Joseph Burke

(a) Residence. No. RD #3 St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. — yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

71B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Singa

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) March 10, 1929

7. AGE — Years — Months 6 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot Ida

PARENTS

10. NAME OF FATHER Earl Burke
11. BIRTHPLACE OF FATHER (city or town) (State or Country) South Dakota
12. MAIDEN NAME OF MOTHER Sadie Wadsworth
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Earl P Burke
(Address) Blackfoot R 3

15. Filed Sept 12, 1929 Wm Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5, 1929, to Sept 11, 1929
that I last saw him alive on Sept 11, 1929
and that death occurred, on the date stated above, at 8:30 P m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
..... (duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Exam Spinal fluid
(Signed) W W Beck, M. D.
Sept 12, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery — Date of Burial: Sep 11 1929

20. Undertaker: E J Peck — Address: Blackfoot

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67525

PLACE OF DEATH

County of Bingham
City of Blackfoot

CERTIFICATE OF DEATH

Registration District No. 121
Primary Registration District No. 2194
(No. Blackfoot Tent Hosp)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 159

2. FULL NAME Oleen Lafayette Grimmett

188 e

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept. 4 - 1912

7 AGE 16 Years | Months 11 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Moreland, Idaho

PARENTS
10 NAME OF FATHER Hyrum A. Grimmett
11 BIRTHPLACE OF FATHER (city or town) (State or country) Dingle, Bear Lake Co. Idaho
12 MAIDEN NAME OF MOTHER Anna C. McBride
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hyrum Utah

14 Informant Hyrum A. Grimmett
(Address) Moreland, Idaho. Box 93

15 Filed Sept. 9, 1929 Mrs Walter E. Calvin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 8 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 8, 1929, that I last saw him alive on Sept 8, 1929, and that death occurred, on the date stated above, at 8.a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Automobile Accident

..... (duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F. A. Mitchell, M. D.
9/8/, 1929 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: [illegible] | Date of Burial 19

20. Undertaker: [illegible] | Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Current Complete August 1929

Bingham Co.

RECEIVED OCT 7 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67526

CERTIFICATE OF DEATH

County of Ft. Hall Reservation Idaho.

City of

Registration District No. I2I-R

Primary Registration District No. 2I94-R

Local Registrar's No. 158

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cataline Martin

3)

(a) Residence. No. ------ St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Shoshone Ind. I5/I6

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): May I3, I927

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
2	2	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ft. Hall Reservation

PARENTS

10. NAME OF FATHER: James Martin

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ft. Hall Reservation

12. MAIDEN NAME OF MOTHER: Phoebe Burton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Birch Creek, Idaho

14. Informant: William Burton,
(Address) Ft. Hall, Idaho

15. Filed Sept. I5, 1929 Mrs Charles E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 6, I929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1929, to Aug. 6, I929, 19
that I last saw her alive on Aug. 5, I929, 19
and that death occurred, on the date stated above, at 2: P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) yrs. I mos. ds.

CONTRIBUTORY (Secondary) ****

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -----

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Henry R. Wheeler, M. D.

, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Butte Cemetery, Ft. Hall Reservation, Aug. 8 19

Date of Burial

20. Undertaker: William Burton, Ft. Hall, Ida

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Bingham Co. Current Complete August. 1929.

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67527

PLACE OF DEATH

County of Ft. Hall Reservation
City of Idaho

Registration District No. I2I- R
Primary Registration District No. 2I94-R
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 157

2. FULL NAME Leslie Weiser

(a) Residence. No. ** St. --- 162
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Shoshone Ind. 4/4
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6. DATE OF BIRTH (month, day and year) July 6, 1929

7. AGE: Years | Months | Days 28 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft. Hall Reservation

PARENTS

10. NAME OF FATHER Luke Weiser
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ft. Hall Reservation
12. MAIDEN NAME OF MOTHER Irene Lewis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ft. Hall Reservation

14. Informant Irene Lewis
(Address) Ft. Hall, Idaho.

15. Filed Sept. I5, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 2, 1929 19
(Month) (Day) (Year)
No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Cholera Infantum.

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) ------
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ---
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Henry V. Wheeler M. D.
....., 19..... (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Presbyterian Mission Ft. Hall Reservation, Aug. 3, 19
Date of Burial

20. Undertaker: Luke Weiser, Ft. Hall, Idaho
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Bingham Co Current Complete July 1929

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67528

PLACE OF DEATH

County of Ft. Hall Reservation, Idaho

City of Ft. Hall

CERTIFICATE OF DEATH

Registration District No. I2I- R.

Primary Registration District No. 2I94-R

Local Registrar's No. 156

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Annie Yogoshoah

117

(a) Residence. No. Ft. Hall, Idaho. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Fred Yogoshoah

6. DATE OF BIRTH (month, day and year): I87I

7. AGE: Years 58 | Months -- | Days -- | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Lemhi Reservation

PARENTS

10. NAME OF FATHER: James Shay

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Lemhi Reservation

12. MAIDEN NAME OF MOTHER: Mattie By-yah

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Lemhi Reservation

14. Informant: Bessie Pohipe

(Address): Ft. Hall, Idaho

15. Filed Sept. I5, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July I9, I929. 19..... (Month) (Day) (Year)

Treated by Dr. Egbert, Arco, Ida.

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Peritonitis

..... (duration) ..... yrs. ..... mos. I ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry R. Wheeler, M. D.

....., 19..... (Address) Ft. Hall Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ft. Hall Reservation, | Date of Burial: July 22 19

20. Undertaker: Brown, Eldredge, | Address: Blackfoot, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current Complete July 1929.

RECEIVED OCT 7 1929

Bing Lam Co. State of Idaho Ft. Hall

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67529

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. I2I- R.

Primary Registration District No. 2I94-R

Local Registrar's No. 155

(No. St. Anthony Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Reita Nagashoah

(a) Residence. No. (Fort Hall Reservation) St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6. DATE OF BIRTH (month, day and year) Aug. I2, I923

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
5	I0	I9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft. Hall Reservation

PARENTS

10. NAME OF FATHER William Nagashoah

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemhi Reservation

12. MAIDEN NAME OF MOTHER Annie Jackson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ft. Hall Reservation

14. Informant William Nagashoah
(Address) Ft. Hall, Idaho.

15. Filed Sept. I5, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July I, I929 19
(Month) (Day) (Year)

Treated by Dr. Clothier, Pocatello

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 9:20 P m.

The CAUSE OF DEATH* was as follows:

Fractured ribs; punctured lung and liver, due to auto accident.

(duration) 2o minutes ds.

CONTRIBUTORY (Secondary) Internal hemorrhage

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Coroners inquest

(Signed) Harry R. Wheeler M. D.

, 19 (Address) Ft. Hall, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Presbyterian Mission Ft. Hall Reservation

Date of Burial: 7-5 19

20. Undertaker: H. L. Mc. Han, Pocatello, Idaho

Address

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67530

PLACE OF DEATH
County of Bingham
City of Woodville

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 168

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ethel Deandra 48a

(a) Residence. No. R I Shelley Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) 11-13-1926

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	8	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Woodville Ida

PARENTS
10. NAME OF FATHER William Deandra
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Woodville Ida
12. MAIDEN NAME OF MOTHER Thelma Gifford
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Woodville Ida

14. Informant William Deandra
(Address) R I Shelley Ida

15. Filed Oct 7, 1929 McCallum E Catanese
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 31st (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-2, 1929, to 8-31, 1929
that I last saw her alive on 8-31-, 1929
and that death occurred, on the date stated above, at 10:30 a.m.
The CAUSE OF DEATH* was as follows:
Ulcerative Endocarditis
(duration) yrs. mos. 30 ds.
CONTRIBUTORY (Secondary) Congenital dextro Cardia (duration) 2 yrs. 8 mos. 16 ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? yes Date Aug 16th Rupt. of Pericardium
Was there an autopsy? no
What test confirmed diagnosis? Aug 31 - 10 a.m. 17th + 30th
(Signed) Edwin Carter, M. D.
8-31, 1929 (Address) Shelley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Cemetery	9-1- 1929

20. Undertaker — Address None Employed

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67531

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 167

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Mrs Annie Holm

(a) Residence. No. Shelley Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 2 - 1846

7. AGE 83. Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Paul Jacobson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Geo F Lofgren
(Address) Shelley Idaho

15. Filed Sept 29, 1929 Mrs Walter E Eaton
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1929, to Sept. 22, 1929
that I last saw her alive on Sept. 22, 1929
and that death occurred, on the date stated above, at 11.30 a.m.
The CAUSE OF DEATH* was as follows:

Old age

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Myocarditis
Short time (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) [illegible], M. D.
Sept 24, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley Ida | Date of Burial Sept 24 1929

20. Undertaker Cliff C Hayes | Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 8 1929

PLACE OF DEATH

County of Enroute N.P.RR

City of Train No. 3

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78

Primary Registration District No. 2155

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67532

Local Registrar's No.

90

2. FULL NAME Roy Percy Cook

(a) Residence. No. St. Billings Montana
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ethel Edna Cook

6. DATE OF BIRTH (month, day and year): Sept. 3, 1886

7. AGE: Years 43; Months; Days 25; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Day

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kansas City Missouri

PARENTS

10. NAME OF FATHER: UnknOwn

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mary Harmelson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Ethel Edna Cook

(Address): Billings Mont.

15. Filed Sept 30, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 28th (Day) 19 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 2:55 p m.

The CAUSE OF DEATH* was as follows:

Did not attend- Diagnosis from post mortem appearance

Chronic Heart Disease History 1 year (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Kidney complication

(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) , M.D.

Sept. 30, 1929 (Address) Sandpoint, Idaho

County Physician

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Seattle Washington — Date of Burial: 19

20. Undertaker: Moon Mortaayy — Address: Sandpoint, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67533

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME JOHN MC KINNON

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 90			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nova Scotia Canada

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant L. G. MOON
(Address) Sandpoint, Idaho.

15. Filed Oct. 1, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 28th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1928, to Sept-28, 1929
that I last saw him alive on Sept-27, 1929
and that death occurred, on the date stated above, at 2:30p. m.
The CAUSE OF DEATH* was as follows:
Arterio-Sclerosis
(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) Floyd G. Wendle M. D.
Oct. 1, 1929 (Address) Sandpoint, Idaho.
County Physician

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
PINECREST CEMETERY	Oct. 2 1929
20. Undertaker	Address
MOON MORTUARY	SANDPOINT IDA

RECEIVED OCT 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
67534

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No. 5I3 S First)

(If death occurred in a hospital or institution, give its name instead of street and number.)

73

2. FULL NAME Mrs Mae M Bandelin

(a) Residence. No. 5I3 S First St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FeMale

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: O J Bandelin

6. DATE OF BIRTH (month, day and year): Apr 23 1880

7. AGE: Years 49 Months 5 Days 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: Chas. Ishell

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Whitney

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: O J Bandelin
(Address) Sandpoint Ida.

15. Filed Sept. 30, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to June 1, 1929 that I last saw her alive on June 1, 1929 and that death occurred, on the date stated above, at 7:15 m.

The CAUSE OF DEATH* was as follows: Ascending Myelitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm F. Tyler, M. D.

Sept 27, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane Wash — Date of Burial: Oct. 1 1929

20. Undertaker: Turnbull Co — Address: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 _ 1929

PLACE OF DEATH

County of Bonner

City of Sandpoint

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78

Primary Registration District No. 2155

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 67535

Local Registrar's No. .....

2. FULL NAME Alexander ~~Du Bia~~ Dubia

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Delvina ~~Du Bia~~ Dubia

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE: Years about 86 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Unknown Michigan

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown Unknown

14. Informant: E. F. Dubia
(Address): Clarks Forks Idaho

15. Filed Sept 21, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1929, to Sept. 19, 1929 that I last saw him alive on Sept. 18, 1929 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Valvular heart disease and Paresis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Roy A. Wendle, M. D.

Sept. 21, 1929 (Address) County Physician Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clarksfork Ida. | Date of Burial: 9/22 1929

20. Undertaker: L. G. Moon | Address: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67536

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Christian Henry Nelson

90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jessie Nelson

6. DATE OF BIRTH (month, day and year): Feb. 22, 1864

7. AGE: Years 65 | Months 5 | Days 17 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Manitowoc Wisconsin

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Jessie Nelson
(Address): Sandpoint, Idaho.

15. Filed Sept 21, 1929 Viola Allen Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 18, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1927, to Sept., 1927
that I last saw him alive on Sept. 18, 1929
and that death occurred, on the date stated above, at 5:30 p.m.
The CAUSE OF DEATH* was as follows:
Cardio nephritis
Hypertension

(duration) 10 yrs. — mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) R. E. Ross, M. D.

Sept. 21, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery | Date of Burial: Sept. 21 1929

20. Undertaker: Moon Mortuary | Address: Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 8 1929

PLACE OF DEATH

County of Bonner

City of Sandpoint

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78

Primary Registration District No. 2155

DO NOT WRITE IN THIS SPACE
State File No. 67537

Local Registrar's No.

(No.) 91B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Vigue

(a) Residence. No. 322 S. Lavina St.
(Usual place of abode)
Length of residence in city or town where death occurred. 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Vigue

6. DATE OF BIRTH (month, day and year): Apr. 6. 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	5	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Marinette Wisc.

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mary Vigue
(Address): Sandpoint Idaho

15. Filed Sept. 20, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October, 1928, to September 17, 1929
that I last saw h-im alive on September 15, 1929
and that death occurred, on the date stated above, at 8.05 p.m.
The CAUSE OF DEATH* was as follows:

Chronic Arthritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): My various ailments

(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) W. B. Evans M. D.
September 20, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Sept. 20, 1929

20. Undertaker: Moon Mortuary — Address: Sandpoint Ida

RECEIVED OCT 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67538

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No.) Parnell Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Christ Knudson

(a) Residence. No. N Forest Ave St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Grethe Knudson

6. DATE OF BIRTH (month, day and year) Aug 22 1855

7. AGE Years	Months	Days	If LESS than 1 day,
74	0	9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Knute Hanson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Mattie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Carl Knudson
(Address) Sandpoint Idaho

15. Filed Sept. 3, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) I (Day) I929 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 16, 1929, to August 31, 1929
that I last saw him alive on August 31st 1929
and that death occurred, on the date stated above, at 7:30A m.
The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal
Disease
(duration) 1 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) C. B. Evans, M. D.
Sept. 2, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	9/3 1929
20. Undertaker	Address
Todhunter Company	Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67539

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2114-0
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 167

29

2. FULL NAME Grace Viola Wardle
(a) Residence. No. 2165 Lee St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) December 23, 1924

7. AGE Years 4 Months 9 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Williams, California

PARENTS
10. NAME OF FATHER C. C. Wardle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Logan Utah
12. MAIDEN NAME OF MOTHER Nettie Belle Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Blackfoot, Idaho

14. Informant C. C. Wardle
(Address) 2165 Lee Idaho Falls Idaho

15. Filed Sept 14, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11, 1929, to Sept. 13, 1929, that I last saw her alive on Sept. 12, 1929 and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:
Tetanus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
9/16, 1929 (Address) Ida Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Blackfoot, Idaho
Date of Burial Sept 16 1929

20. Undertaker Jack A. Wood
Address Idaho Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. ~~Exact statement of OCCUPATION is very important. See instruction on back of certificate.~~

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67541

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2150
Local Registrar's No. 165
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

179

2. FULL NAME Marilyn Bernadette Hersley.
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Nov. 16-1927
7. AGE: Years 1, Months 9, Days 25. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Idaho Falls. Ida.

PARENTS

10. NAME OF FATHER: Will Hersley.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kansas.
12. MAIDEN NAME OF MOTHER: Mary Ida Koenig.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Will Hersley.
(Address) Idaho Falls Ida.
15. Filed Sept 13, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 11 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 18, 1929 to Sept 11, 1929 that I last saw her alive on Sept 11, 1929 and that death occurred, on the date stated above, at 8:35 P.M.
The CAUSE OF DEATH* was as follows:
Extensive second and third degree Burn over body over 2/5 of Sthn surface
Fell in tub of boiling water (duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Same
(duration) yrs. mos. 2 ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical
(Signed) H D Lynch, M. D.
Sept 12, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: Sept 14 1929
20. Undertaker: V. F. McHan. Address: Idaho Falls Ida.

RECEIVED FEB 28 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67541

Dr. H.D. Junkin
Ida.Falls

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Marilyn Bernadette Hershy who died Sept. 11, 1929
Cause of death given as "Extensive second and third degree burns over 2/5 body surface."

Information DESIRED in order to complete certificate:

WAS A BURNING BUILDING INVOLVED?

PLEASE ANSWER BELOW:

No fell in tub boiling water.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67542

PLACE OF DEATH
County of Bonneville
City of Idaho Falls.

Registration District No. 73
Primary Registration District No. 214-0
(No. Ce-D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 164

161a

2. FULL NAME ~~Lydine~~ + Lydine Farnsworth (Twins)

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept 8-1929

7. AGE: Years 0, Months 0, Days 0, If LESS than 1 day, 1 hrs. or 30 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Ida.

PARENTS
10. NAME OF FATHER: G. W. Farnsworth
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho Falls Ida.
12. MAIDEN NAME OF MOTHER: Helen Oakden
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Swan Valley

14. Informant: G. W. Farnsworth
(Address): Swan Valley Ida.

15. Filed Sept 8, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1929, to ....., 19..., that I last saw her alive on ....., 19..., and that death occurred, on the date stated above, at 230 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth 6½ mo
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Hydrocephalus
(duration) ..... yrs. 3 mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? ..... Date of .....
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature], M. D.
9/8/29, 19.. (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Swan Valley
Date of Burial: Sept 8 1929

20. Undertaker: V. F. McHan
Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

FORM V. S. No. 3-25 M. 1-19

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 214-0

(No. L D S Hospital St.)

State File No. 67543

Local Registrar's No. 163

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ludine Farnsworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: Sept (Month) 8 (Day) 1929 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day, how many 1½ hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho Falls Ida.

10. NAME OF Father: G. W. Farnsworth

11. BIRTHPLACE OF FATHER (State or Country): Idaho Falls Ida

12. MAIDEN NAME OF MOTHER: Helen Oakden.

13. BIRTHPLACE OF MOTHER (State or Country): Swan Valley.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. W. Farnsworth

(Address) ~~Idaho~~ Swan Valley

15. Filed Sept 8 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH 161a

16. DATE OF DEATH: Sept. (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1929, to Sept 28 1929 that I last saw her alive on Sept 28 1929 and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth 6½ mo

(Duration) yrs. mos. ds.

Contributory (Secondary) Hydramnos of mother

(Duration) yrs. 3 mos. ds.

(Signed) [signature] M. D.

9/8 1929 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Swan Valley Ida

DATE OF BURIAL: 9/8 1929

20. UNDERTAKER: V. F. McHan

ADDRESS: Idaho Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R-

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPAC

State File No. 67545

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2 1 0 -0

Local Registrar's No. 161

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

88B

2. FULL NAME Merrell Hughes.

(a) Residence. No. 9 Miles North of I. F. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
83	9	13.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kentucky.

PARENTS

10. NAME OF FATHER: Dan Hughes.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Elizabeth Howard.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown.

14. Informant: R. E. Hughes.
(Address) Idaho Falls Ida.

15. Filed Sept 7, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 26 29 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 5, 1929, that I last saw him alive on July 5, 1929, and that death occurred, on the date stated above, at 10:10 PM

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) ✓ yrs. mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? ✓

(Signed) [signature] M

Sept 7, 1929 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLE CAUSES, state (1) MEANS AND NATURE OF INJURY, and whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls. Ida. Date of Burial: 8/26-29

20. Undertaker: V. F. McHan. Address: Idaho Falls Idaho.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67546

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 1210

Local Registrar's No. 160

(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

118B

2. FULL NAME John C Johnson

(a) Residence No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 7. 1907

7. AGE: Years 22, Months 11, Days 27. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Asst. in Forest Service

(b) General nature of industry, business, or establishment in which employed (or employer): Forest Service

(c) Name of employer: U.S. Forest Service

9. BIRTHPLACE (city or town) (State or country): Columbus Montana

PARENTS

10. NAME OF FATHER: J. O. Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Springfield Ohio

12. MAIDEN NAME OF MOTHER: Tillie Needham

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salt Lake City Ut.

14. Informant: J. O. Johnson
(Address) St Anthony Ida.

15. Filed Sept 5, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13, 1929, to Sept. 4, 1929 that I last saw him alive on Sept 3, 1929 and that death occurred, on the date stated above, at 5 35 A. m.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction following appendectomy
(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary): Same
(duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Aug 23 29

Was there an autopsy? No

What test confirmed diagnosis? Second operation

(Signed) [signature], M. D.

Sept 5, 1929 (Address) Idaho Falls Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Anthony Ida. Date of Burial: 9/6 1929

20. Undertaker: V. F. McHan. Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67547

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2140
(No. Lee S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14-9

117

2. FULL NAME William H. Hutchison

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs W. H. Hutchison

6. DATE OF BIRTH (month, day and year): March 30. 1875

7. AGE: Years 53 | Months 5 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Isabelle Mo.

PARENTS

10. NAME OF FATHER: Marshall. H. Hutchison
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Caroline Fry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Mrs Wm H. Hutchison
(Address): Hamer Idaho.

15. Filed Sept 5, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30, 1929, to Sept 4, 1929
that I last saw him alive on ....., 19..
and that death occurred, on the date stated above, at 10.18 P. m.
The CAUSE OF DEATH* was as follows:
Ruptured Appendix
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Infection Bacilli Welchi
..... (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? Roberts Idaho
Did an operation precede death? Yes Date of Sept. 4-1929
Was there an autopsy? No
What test confirmed diagnosis? Culture - operation
(Signed) H D Junkin, M. D.
Sept 5, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls. Date of Burial: 9/6 1929

20. Undertaker: Vr. F. McHan Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67548

PLACE OF DEATH

County of Bonneville. Registration District No. 23

City of Idaho Falls Primary Registration District No. 2 1 4 -0 Local Registrar's No. 17

(No. L. D. S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Evaline Campbell. 46

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 23-1876.

7. AGE	Years	Months	Days	If LESS than 1 day,
	53	6	12.	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden Utah.

PARENTS

10. NAME OF FATHER David Browning
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Elizabeth J. Garner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ogden Utah

14. Informant Mrs Ned Berry.
(Address) Rigby Idaho.

15. Filed Sept 19, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1929, to Sept 5, 1929
that I last saw her alive on Sept. 4, 1929
and that death occurred, on the date stated above, at 6 5-7 m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis to Brain

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination.

(Signed) W. D. Greene, M. D.
Sept 5, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida.	9/8 1929
20. Undertaker	Address
V. F. McHan	Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED SEP 19 1929

DO NOT WRITE IN THIS SPACE
State File No. 67549

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 147

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lynn C. Judy

(a) Residence. No. Ozone, Idaho St. 205-a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): April 1, 1929

7. AGE: Years | Months: 4 | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child at home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Shelley, Idaho

PARENTS

10. NAME OF FATHER: Alva Clark Judy
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Salem, Idaho
12. MAIDEN NAME OF MOTHER: Louildean Otteson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ucon, Idaho

14. Informant: Alva Judy
(Address): Ozone, Idaho

15. Filed Sept 4, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from not at all, 19, to —, 19
that I last saw ~~him~~ alive on not at all, 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Smothered Possibly child was dead when brought to hospital
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. Ray Hatch, M. D.
Sept 3, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ammon, Idaho | Date of Burial: 8/3 1929

20. Undertaker: Jack A. Wood | Address: Idaho Falls Idaho

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67550

PLACE OF DEATH

County of Bonneville Registration District No. 73

City of Idaho Falls Primary Registration District No. 210-0 Local Registrar's No. 14-6

(No. L. D. S. Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Erma Crow. 117

(a) Residence. No. Iona Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): April 7-1916

7. AGE

Years	Months	Days	If LESS than 1 day,
13	4	25	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ammon Idaho

PARENTS

10. NAME OF FATHER: Walter N. Crow

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Nevada.

12. MAIDEN NAME OF MOTHER: Viola Allen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah.

14. Informant: Walter N. Crow.
(Address) R No 3. Idaho Falls

15. Filed Sept 3, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 2. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26, 1929 to Sept. 2, 1929
that I last saw h[illegible] alive on Sept. 11 1929
and that death occurred, on the date stated above, at 5:35 a.m.

The CAUSE OF DEATH* was as follows:

Suppurative appendicitis and salpingitis

(duration) yrs. mos. ds.

General deffuse peritonitis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A Millar M. D.

Sept 3, 1929 (Address) Idaho Falls,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Iona Idaho	9/4 1929.
20. Undertaker: V. F. McHan.	Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67551

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 77
Primary Registration District No. 2140
Local Registrar's No. 155
(No. Le D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Joseph Allen Kelly
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 hrs. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 30 1929
7. AGE Years no Months no Days no If LESS than 1 day, 5 hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho Falls Ida.

PARENTS
10. NAME OF FATHER Boyd C. Kelly.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska.
12. MAIDEN NAME OF MOTHER Mary O'Neil
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Daniel Wyo.

14. Informant Ruth O'Neil
(Address) Daniel Wyo.
15. Filed Aug 31, 1927 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 30 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw him alive on ....., 19...
and that death occurred, on the date stated above, at 8:30 p. m.
The CAUSE OF DEATH* was as follows:
Premature birth
4 hours
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) [signature], M. D.
....., 19... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls Ida. Date of Burial 8/31 1929.
20. Undertaker V. F. McHan Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPAC

State File No. 67552

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 23

Primary Registration District No. 2 1 1 0

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1 V 4

2. FULL NAME Lillian Harrison Ford

(a) Residence. No. 11 E Street St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of B. H. Ford

6. DATE OF BIRTH (month, day and year) Sept. 13, 1883

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	11	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bountiful, Utah

PARENTS

10. NAME OF FATHER Henry Harrison

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bountiful, Utah

12. MAIDEN NAME OF MOTHER Clara Ashdown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant B. H. Ford

(Address) Idaho Falls, Idaho

15. Filed Aug 30, 1929 J. Jefferies Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 27 1929

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to Aug. 27, 1929

that I last saw h[illegible] alive on Aug. 26, 1929

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene, Secondary Anemia

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Idaho Falls

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John O. Millar M. D.

Aug. 30, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho	Aug 30 1929

20. Undertaker Jack A. Wood Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67553

PLACE OF DEATH
County of Bonneville.
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 1 V -0
(No. L. D. S. Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1 V -3

34

2. FULL NAME Agnes Blanche Roark.

(a) Residence. No. Main St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. M.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Divorced.

5a. If married, widowed, or divorced ~~XXXXXXXXXX~~ (or) WIFE of Oscar Jennings Roark.

6. DATE OF BIRTH (month, day and year) Jan 15 1888

7. AGE Years 41 Months 7 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House keeper.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Edgar C. Howe.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Annie Augusta Talmadge.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Mrs F. S. Johnson
(Address) Rigby, Idaho.

15. Filed Aug 30, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26, 1929, to Aug 28, 1929
that I last saw her alive on Aug 27, 1929
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:
Meningitis (syphilitic)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Syphilis
(duration) ? yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Wasserman
(Signed) [signature], M. D.
Aug 29, 1929 (Address) Rigby

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rigby, Idaho. Date of Burial 8/30/29

20. Undertaker [signature] Address Rigby

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67554

Registration District No. 73
Primary Registration District No. 2 4 1 9
Local Registrar's No. 15-2

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Refugio Hernandez
(a) Residence. No. Idaho Falls, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Not Known

7. AGE: Years 28 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cafe Owner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mexico

PARENTS

10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: B. J. Allen
(Address): Idaho Falls, Idaho

15. Filed Aug 27, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 5-50 P m.

The CAUSE OF DEATH* was as follows:
Fractured Skull
Concussion of Brain
Accident Fall to Wreck
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of Aug 23-29
Was there an autopsy? no
What test confirmed diagnosis? Findings from
(Signed) [illegible] M.D.
Aug. 27-29 (Address) Coroner Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho — Date of Burial: Aug 27 1929
20. Undertaker: Jack A. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67555

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 151

183

2. FULL NAME Warren Thurlin
(a) Residence. No. Stuart, Iowa St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 25, 1907

7. AGE Years 21 Months 10 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Stuart, Iowa

PARENTS
10. NAME OF FATHER N. A. Thurlin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Ida Lou
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Stuart, Iowa

14. Informant Harold Thurlin
(Address) Stuart, Iowa

15. Filed Aug 27, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25, 1929, to Aug 25, 1929
that I last saw him alive on Aug 25, 1929.
and that death occurred, on the date stated above, at 12:30 p.m.
The CAUSE OF DEATH* was as follows:
Accidental Gun shot wound

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Multiple Fracture + Hemorrhage
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Aug 25-29
Was there an autopsy? yes
What test confirmed diagnosis?
(Signed) Dr. B. J. Allen D.C.
Aug 27, 1929 (Address) Coroner Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Stuart, Iowa
Date of Burial Aug 30 1929

20. Undertaker Jack A. Wood
Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67556

PLACE OF DEATH
County of Bonneville. Registration District No. 73
City of Idaho Falls. Primary Registration District No. 214-0
Local Registrar's No. 150

(No. 240) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Jones.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white.	married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Geraldine Jones.

6. DATE OF BIRTH (month, day and year) May 18- 1886.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	3	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Elk Creek. Neb.

PARENTS

10. NAME OF FATHER William H. Jones.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Fannie.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant Mrs. G. C. Jones.
(Address) Idaho Falls Ida

15. Filed Aug 23, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw him alive on ....., 19.....
and that death occurred, on the date stated above at 6 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) C. A. Fallon Coroner
Aug 23, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Elk Creek. Neb.	Aug 26 1929.
20. Undertaker V. F. McHan	Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67557

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 214-1
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 149

2. FULL NAME Celia Anderson Dawson 34

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Divorced.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 22-1883

7. AGE 46 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10. NAME OF FATHER Eric Ventor.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nut.
12. MAIDEN NAME OF MOTHER Nancy Wakeley.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know.

14. Informant Mr. J. G. Ventor.
(Address) Bethel Idaho

15. Filed Aug 23, 1929 [signature] Registrar
Dr. Jenkins.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1929, to Aug 22, 1929
that I last saw her alive on Aug 22, 1929
and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:
Tues
..... (duration) several yrs. ..... mos. .....
CONTRIBUTORY (Secondary) Fibroid of uterus c̄ hemorrhage.
..... (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of Aug 13-29
Was there an autopsy? No
What test confirmed diagnosis? Op. Wassermann
(Signed) H D Jenkins, M. D.
Aug 28, 1929 (Address) Idaho Falls Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Afton Wyoming. Date of Burial: Aug 24 1929

20. Undertaker: Cliff Hayes. Address: Idaho Falls

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67558

PLACE OF DEATH
County of Lemhi
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 1 7
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 145

2. FULL NAME Nathan Alvin Packer

(a) Residence No. 1575 Idaho Ave., St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Elizabeth Packer

6. DATE OF BIRTH (month, day and year): June 16, 1873

7. AGE: Years 56 | Months 2 | Days 2 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Transfer Driver
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Franklin, Idaho

PARENTS

10. NAME OF FATHER: James Packer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Mrs. Nathan Packer
(Address) Idaho Falls, Idaho

15. Filed Aug 22, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 18 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17, 1929, to Aug 18, 1929, that I last saw h alive on Aug 17, 1929, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Embolism
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) H. D. Larkin, M. D.
Aug 22, 1929 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Idaho — Date of Burial: Aug 22 1929
20. Undertaker: Jack A. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67559

Registration District No. 73

Primary Registration District No. 21050

Local Registrar's No. 147

(No. L. O. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myrtle Wilcox Wright

140

(a) Residence. No. 205 - I. St. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wilbur Wright

6. DATE OF BIRTH (month, day and year) April 26, 1892

7. AGE Years 37 Months 3 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Farmington Utah

PARENTS

10. NAME OF FATHER J. L. Wilcox

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Annie Rice

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Wilbur Wright

(Address) Idaho Falls Idaho

15. Filed Aug 22, 1929 Wm Kimaird Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1929, to Aug 21, 1929 that I last saw her alive on Aug 21, 1929 and that death occurred, on the date stated above, at 4-30 p m.

The CAUSE OF DEATH* was as follows:

Intra abdominal Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Laparotomy

Uterine Suspension (duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of Aug 21-29

Was there an autopsy? No

What test confirmed diagnosis? Secondary operation

(Signed) H D Hendrix, M. D.

Aug 22, 1929 (Address) Idaho Falls Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bountiful, Utah

Date of Burial Aug 24 1929

20. Undertaker Jack G. Wood

Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67560

PLACE OF DEATH

County of Bonneville

City of Idaho Falls, Idaho.

Registration District No. 73

Primary Registration District No. 2 14-0

Local Registrar's No. 46

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George William Hill

(a) Residence. No. ..... St. 44
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married.

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Ellen Hill.

6. DATE OF BIRTH (month, day and year) Jan. 7, 1868

7. AGE: 61 Years | Months: 7 | Days: 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer: Self.

9. BIRTHPLACE (city or town) (State or country): Utah.

PARENTS

10. NAME OF FATHER: George Hill,

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England.

12. MAIDEN NAME OF MOTHER: Harriett Bassett.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah.

14. Informant: Mary Ellen Hill
(Address) Rigby, Idaho Rt. #2.

15. Filed Aug 22, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1929, to Aug 14, 1929 that I last saw him alive on Aug 14, 1929 and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Adeno Carcinoma of Stomach
Pyloric Obstruction
(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Gastric Ulcer
(duration) 20 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Rigby Idaho

Did an operation precede death? yes Date of Aug 13, 1929

Was there an autopsy? no

What test confirmed diagnosis? Exploratory

(Signed) [signature], M. D.

Aug 15, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby, Idaho. | Date of Burial: 8/18/29 19

20. Undertaker: A B Eckersell | Address: Rigby, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 19 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 73

Primary Registration District No. 3 1 N 0

(No. L.D.S.Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67561

Local Registrar's No. 145

SD

2. FULL NAME Frederick Augustus Caine

(a) Residence. No. 542 - K Street St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Hazel H.Caine

6. DATE OF BIRTH (month, day and year) March 24,1884

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	45	4	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Real estate & Insurance

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coalville, Utah

PARENTS

10. NAME OF FATHER Alfred H.Caine

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Margaret A.Mitchell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Alma O.Taylor

(Address) Salt Lake City, Utah

15. Filed Aug 17, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5, 1928 to Aug. 14, 1929 that I last saw h[illegible]live on Aug. 14, 1929 and that death occurred, on the date stated above, at 1-30 P m.

The CAUSE OF DEATH* was as follows:

Leiomyo-sarcoma Mediastinum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases to abdominal Cavity

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-rays

(Signed) John O. Pelly M. D.

Aug 16, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salt Lake City, Utah	August 19 29
20. Undertaker	Address
J.A.Wood	Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67562

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2140

Local Registrar's No. 144

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marjie Kunz

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

156

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 2 1923

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
6	6	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Ida.

PARENTS

10. NAME OF FATHER Samuel Kunz jr.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ovid Idaho.

12. MAIDEN NAME OF MOTHER Foster.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Camp Floyd Utah

14. Informant Samuel Kunz

(Address) Driggs Idaho

15. Filed Aug 12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1929, to Aug 10, 1929 that I last saw her alive on Aug 10, 1929 and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows: Acute General peritonitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Perityphlitis ?

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Driggs Idaho

Did an operation precede death? yes Date of Aug 9, 1929

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) H Kaz Hatch M. D.

Aug 11, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Driggs Ida. Date of Burial: Aug 14 1929

20. Undertaker: V. F. McHan Address: Idaho Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67563

PLACE OF DEATH
County of Bonneville
City of Iona

Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 143

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

182

2. FULL NAME George Hutchinson
(a) Residence. No. Raymond, Alberta Canada St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 18, 1910

7. AGE: Years 19 Months 4 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Brandon, Manitoba

PARENTS

10. NAME OF FATHER: Elias J. Hutchinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Onta Canada
12. MAIDEN NAME OF MOTHER: Mary Jane Foster
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Wilford Lee
(Address) Iona, Idaho

15. Filed Aug 5, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Drowning
Accidental
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) Dr B J Allen M. D.
Aug 8, 1929 (Address) Coroner Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Iona, Idaho — Date of Burial: Aug. 8 1929

20. Undertaker: Jack A. Hood — Address: Idaho Falls

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67564

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21-4-0
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14 r

2. FULL NAME Leon Richards
(a) Residence. No. 425 - 7th St. St. 44
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Richards

6. DATE OF BIRTH (month, day and year) February 4, 1873

7. AGE: Years 56, Months 5, Days 2. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clay Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Challais, Idaho

PARENTS
10. NAME OF FATHER John Richards
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs. Leon Richards
(Address) Idaho Falls, Idaho

15. Filed Aug 7, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1929, to Aug 6, 1929
that I last saw him alive on Aug 6, 1929
and that death occurred, on the date stated above, at 11 30 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma Stomach

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of March 3-29
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) A. R. Sodenquist, M. D.
8/9, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho — Date of Burial: Aug. 9 1929

20. Undertaker: Jack A. Wood — Address: Idaho Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67565

PLACE OF DEATH
County of Bonneville. Registration District No. 73
City of Idaho Falls. Primary Registration District No. 21-10
Local Registrar's No. 141
(No. L. D. S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1613

2. FULL NAME Max Gerald Sandlis.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 31-1929.

7. AGE: Years 0 | Months 0 | Days 0 | If LESS than 1 day, 20 hrs. or 2 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls.

PARENTS
10. NAME OF FATHER: Alon Sandlis.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada.
12. MAIDEN NAME OF MOTHER: Alice Rushton.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Oregon.

14. Informant: Alon Sandlis.
(Address): Idaho Falls Ida.

15. Filed Aug 3, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 31 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to July 31, 1929, that I last saw him alive on July 31, 1929, and that death occurred, on the date stated above, at ( ) m.

The CAUSE OF DEATH* was as follows:
Asphyxiation in birth
Version & Extraction
(duration) yrs. mos. 1 hr ds.
CONTRIBUTORY (Secondary) Shoulder presentation dry Labor
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? Pocatello Ida
Did an operation precede death? yes Date of July 31
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) [illegible], M. D.
July 31, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls.	Aug 1 1929
20. Undertaker: D. F. McHan.	Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67566

PLACE OF DEATH

County of Bonneville. Registration District No. 3

City of Idaho Falls. Primary Registration District No. 214-0

Local Registrar's No. 140

(No. Kettering Sanitarium
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ida Augusta Forneten. 46

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 19 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 2. 1869

7. AGE — Years: 60 | Months: 6 | Days: 2 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10. NAME OF FATHER: L. O. Meppen.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.
12. MAIDEN NAME OF MOTHER: Margarette Stalp
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Henry T. Forneten
(Address) Idaho Falls. Ida.

15. Filed Aug 3, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 8, 1929 to July 30, 1929 that I last saw h[illegible] alive on July 30 1929 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? V

Did an operation precede death? Yes Date of Apr 13-29.

Was there an autopsy? No

What test confirmed diagnosis? Operation & tissue.

(Signed) [illegible], M. D.

Aug 1, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	Aug 2 1929

20. Undertaker: V. F. McHan. Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67567

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 3
Primary Registration District No. 2007
(No. 161a)
Local Registrar's No. 8

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Katie Orth

(a) Residence. No. [redacted] St. Parma Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Sept. 19-1929

7. AGE — Years — Months — Days: One. If LESS than 1 day, — hrs. or — min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Parma Idaho

PARENTS

10. NAME OF FATHER Ira Orth
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Plymouth Neb.
12. MAIDEN NAME OF MOTHER Minnie Rohfling
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Plymouth Neb.

14. Informant Ira Orth
(Address) Parma Idaho.

15. Filed Oct 10, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19, 1929, to Sept 21, 1929
that I last saw h[illegible] alive on Sept 21, 1929
and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows: Premature birth seven months.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? None.
Did an operation precede death? No. Date of —
Was there an autopsy? No.
What test confirmed diagnosis? None

(Signed) W. M. Mitchell M. D.
9-24, 1929 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

RECEIVED OCT 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67568

PLACE OF DEATH
County of Canyon
City of Parma — Registration District No. ____
Primary Registration District No. 2007
Local Registrar's No. 6
(No. ____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Emma Arnett

(a) Residence. No. ____ Parma St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Henry W. Arnett

6. DATE OF BIRTH (month, day and year) Jan 6 1871

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	58	8	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer ____

9. BIRTHPLACE (city or town) (State or country) St Paul Minnesota

PARENTS

10. NAME OF FATHER John Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Rosa Godfrey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minnesota

14. Informant Henry W Arnett
(Address) Parma Idaho

15. Filed Oct 10, 1929 Lucius Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22, 1929, to Sept 23, 1929
that I last saw her alive on Sept 23, 1929
and that death occurred, on the date stated above, at 11-35 a.m.
The CAUSE OF DEATH* was as follows:
Diabetic Gangrene
(duration) about — yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Diabetes Mellitus
(duration) about 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? no Date of ____
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) W. E. Nuttall, M. D.
Sept 25, 1929 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parma Cem	9/25 1929
20. Undertaker C. V. Peckham	Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 _ 1929

STATE O. IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67569

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5

48B

2. FULL NAME Bessie Corrin
(a) Residence. No. Parma Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: W. W. Corrin

6. DATE OF BIRTH (month, day and year): Mch-11-1899

7. AGE: Years 30, Months 5, Days 20. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Mano Missouri

PARENTS

10. NAME OF FATHER: C. S. Burton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Mary E. Chappell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mano Missouri

14. Informant: W. W. Corrin
(Address): Parma Ida

15. Filed Oct 10, 1929 Lulu Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 1 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1929, to Sept. 1, 1929
that I last saw her alive on Sept 1, 1929
and that death occurred, on the date stated above, at 9-45 P.m.
The CAUSE OF DEATH* was as follows:
Acute Myocarditis
(duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) Peritoneal Absorption toxins
old Rupt. tubal Preg. (duration) ..... yrs. ..... mos. 20 ds.

18. Where was disease contracted if not at place of death? Parma Ida
Did an operation precede death? Yes Date of Aug 27-29
Was there an autopsy? No
What test confirmed diagnosis? Operative & Clinical
(Signed) S. B. Dudley, M. D.
Sept-6, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Parma Cem
Date of Burial: 9-4 1929

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 9 – 1929

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 1006

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 67570

Local Registrar's No. 100

164

2. FULL NAME Lewis Mc Callum

(a) Residence. No. 401 – 10 ave S St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mrs Mary Mc Callum

6. DATE OF BIRTH (month, day and year) Apr 26 – 1846

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	4	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer (retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10. NAME OF FATHER Robt Mc Callum

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Anna Mc Key

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs Mary Mc Callum

(Address) Nampa Ida

15. Filed 9-9, 1929 Martha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep 7 19 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1928, to Sep 7, 1929

that I last saw him alive on Sep 9, 1929

and that death occurred, on the date stated above, at 1140 P m.

The CAUSE OF DEATH* was as follows:

General Paresis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) H. H. Rowe, M. D.

Sep 8, 1929 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Idaho	Sep 10 1929
20. Undertaker	Address
Fred K. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 9 – 1929

PLACE OF DEATH

County of Canyon

City of Rural

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 2016

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67571

Local Registrar's No. 101

164

2. FULL NAME Elizabeth Martin

(a) Residence. No. 2½ miles West Nampa
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Sept 23 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	11	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS

10. NAME OF FATHER Riley Simmons

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Caroline Ross

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill

14. Informant W. B. Martin

(Address) Nampa Ida

15. Filed 9-21, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1927, to Sept 21, 1929

that I last saw her alive on Sept 19, 1929

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion from age and Chronic Intestinal Disease for many years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

9 21, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Half Way Ought	— 19

20. Undertaker	Address
Fred K. Robinson	Nampa Ida

RECEIVED OCT 9 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67572

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 102
(No. 1½ mi. so. east Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Wm Fisher

(a) Residence. No. 1½ mi. so. east Nampa St.
(Usual place of abode)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Alice Fisher

6. DATE OF BIRTH (month, day and year) Oct. 23rd 1856

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	10	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Little Rock Arkansas

PARENTS

10. NAME OF FATHER Thomas Wm Fisher

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Martha Horton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas

14. Informant Mrs. J. W. Fisher
(Address) Nampa, Idaho

15. Filed 9-15, 1929 Seth Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 13th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22, 1928, to Sept 13, 1929
that I last saw him alive on Sept 13, 1929
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Cerebro sclerosis.
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) V. C. Isely M. D.
9-14-, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Star - Idaho	9-15 1929
20. Undertaker	Address
Wm D. Talley	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED OCT 9 - 1929

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67573

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 103

(No. 1114-14th Ave. So)

(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Harry Lee Biggs

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 23rd 1929

7. AGE Years Months Days If LESS than 1 day, 6 hrs. or 30 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Nampa
(State or country) Idaho

PARENTS

10. NAME OF FATHER G. M. Biggs

11. BIRTHPLACE OF FATHER (city or town) Roseberry
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ruth Hamilton

13. BIRTHPLACE OF MOTHER (city or town) Sioux City
(State or Country) Iowa

14. Informant Mr. G. M. Biggs
(Address) Nampa, Idaho

15. Filed 9-23, 1929 S. Esther Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 23rd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7 P.M. 9/23, 1929, to 6 P.M. 9/23, 1929 that I last saw him alive on Sept 23, 1929 and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mother had Fine Cut Erg normal no instruments (duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. A. Meredith D.C., M. D.

Sept 24, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa

Date of Burial: 9-24-1929

20. Undertaker: Mrs. Nina M. Talley

Address: Nampa, Ida

RECEIVED OCT 9 – 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67574

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. ✓)
Local Registrar's No. 109

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Troyer 89

(a) Residence. No. 520 – 11 ave So St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Jessie L. Troyer

6. DATE OF BIRTH (month, day and year) Jan 26 – 1873

7. AGE Years	Months	Days	If LESS than 1 day,
56	7	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Grocerman
(b) General nature of industry, business, or establishment in which employed (or employer) (manager)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Joseph Troyer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Elizabeth Schrock
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs Frank Troyer
(Address) Nampa Idaho

15. Filed 9-30, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-19, 1929, to 9-23, 1929
that I last saw h~~im~~ alive on 9-19, 1929
and that death occurred, on the date stated above, at 4:30 P m.
The CAUSE OF DEATH* was as follows:

Cangina Pectoris
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Left Coronary
Sclerosis (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? Yes.
What test confirmed diagnosis? Autopsy.
(Signed) J. Horton M. D.
9-30, 1929 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa, Idaho	9-29 1929
20. Undertaker Fred K. Robertson	Address Nam.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67575

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 105
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

140

2. FULL NAME Mary Ellen Lee
(a) Residence. No. 111 – 15th Ave So. St.
(Usual place of abode)
Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Frank Lee

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 60			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10. NAME OF FATHER ——— Quinn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mr. Frank Lee Jr.
(Address) Nampa Idaho

15. Filed Oct 2, 1929 Estella Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 23, 1929, to Sep 26, 1929, that I last saw ~~her~~ alive on Sep 26 1929, and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Femoral Hernia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of Sep 25/29
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) H. Ryan, M. D.
Oct 2, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. Calvary Nampa	9-28 1929
20. Undertaker	Address
Mrs Nina M. Talley	Nampa, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67576

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 103
(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Susanna Miller
(a) Residence. No. Indiana St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Oct 26 1850
7. AGE: Years 78 | Months 11 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS
10. NAME OF FATHER: Sebastian Kagy
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Don't know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn.

14. Informant: J A Miller
(Address) Caldwell Ida
15. Filed 10-7-, 1929. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 2 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 15 1929, to Oct 2, 1929
that I last saw her alive on Oct 1 at, 1929
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Myo - Cardelis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Angina
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis?
(Signed) C D Forrer, M. D.
Oct 7, 1929 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill.	10/4 1929
20. Undertaker C. V. Peckham	Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67577

PLACE OF DEATH

County of Canyon

City of Notus

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 102

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lloyd Ivie

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 5-11- 1911

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
18	4	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Ranching

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Cleveland Ida

PARENTS

10. NAME OF FATHER: Bert Ivie

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ella M Lloyd

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

Bert Ivie

14. Informant

(Address) Notus Ida R 1

15. Filed 10-8-, 1929 — John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 7 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Oct 7, 1929 that I last saw him alive on Oct 7, 1929 and that death occurred, on the date stated above, at 6 40 P m.

The CAUSE OF DEATH* was as follows: Hemmorrhage & Shock from shot gun wound of femoral artery

..... (duration) ..... yrs. ..... mos. 3 hours

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [signature] M. D.

10/8, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill

Date of Burial: 10-11-29

20. Undertaker: Paul L. Case

Address: Caldwell Idaho

RECEIVED OCT 10 '29

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67578

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1009

Local Registrar's No. 101

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

41

2. FULL NAME Geo Washington Green

(a) Residence. No. 716 N 9 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Cecil S. Green

6. DATE OF BIRTH (month, day and year) Oct 27

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	11	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Elmira Oregon

PARENTS

10. NAME OF FATHER Taylor B. Green

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Cecile Green
(Address) Caldwell Ida

15. Filed 10-3-, 1929 John L. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1929, to Sept 29, 1929, that I last saw h- alive on Sept 29, 1929, and that death occurred, on the date stated above, at 1-300 m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Kidney stone operation (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug 29

Was there an autopsy? no

What test confirmed diagnosis? Clinical history

(Signed) W. M. Montgomery M. D.

9/3, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Oct 2 1929
20. Undertaker V. V. Peckham	Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

PLACE OF DEATH

County of Canyon

City of Huston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67579

Local Registrar's No. 100

129

2. FULL NAME Mary Ann Hallseth

(a) Residence. No. Huston #2 St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white.

5. Single, Married, Widowed, or Divorced (write the word): widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 4 1851

7. AGE: Years 77; Months; Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois.

PARENTS

10. NAME OF FATHER Wm Lovel

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri.

12. MAIDEN NAME OF MOTHER Julia Ann Edmons

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Don't know.

14. Informant: Jones Funeral

(Address) Huston Idaho #2

15. Filed 9-23-, 1929 John L. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 21 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18, 1929, to Sept 21, 1929, that I last saw her alive on Sept 18, 1929, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C C Zeltman M. D.

Sept. 21, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill.	Sept. 23 1929
20. Undertaker C V Peckham	Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Cal RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67580

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 99

74a

2. FULL NAME Mary Jane Bartlett
(a) Residence. No. Caldwell #3 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct-8-

7. AGE 80 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER Wm Moore
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Thomasine Foggitt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant T. M. Bartlett
(Address) Caldwell, Ida.

15. Filed 9-22-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 19- 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to Sept 19, 1929
that I last saw her alive on Sept 12, 19
and that death occurred, on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) [signature] M. D.
9/20, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pleasant Ridge | Date of Burial Sept. 22- 1929

20. Undertaker C. V. Peckham | Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67581

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 98

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harold Joshua Jester

(a) Residence. No. 16th & Washington St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 15 1899

7. AGE Years: ~~32~~ 30 Months: 4 Days: 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Draftsman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: H. J. McNeal

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10. NAME OF FATHER: J. Jester, Jr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Cryntheez Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Karen M. Jester
(Address) Caldwell, Idaho

15. Filed 9-14-, 1929 John K. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1928, to Sept 12, 1929
that I last saw him alive on Sept 12, 19..
and that death occurred, on the date stated above, at 4-45 P. m.
The CAUSE OF DEATH* was as follows:
Septic endocarditis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) [signature] M.D.
9/14, 1929 (Address) Cordova Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: Sept 15 1929

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67582

PLACE OF DEATH

County of Canyon
City of Middleton

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 97

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mabel M. Crockett

(a) Residence. No. Middleton Idaho St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 26-18

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
51			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home-wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Middleton Iowa

PARENTS

10. NAME OF FATHER Moriston
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Frank Crockett
(Address) Middleton

15. Filed 10-1-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 27, 1928, to Sept 10, 1929
that I last saw her alive on Sept 10, 1929
and that death occurred, on the date stated above, at 10-15a.m.

The CAUSE OF DEATH* was as follows:
Carcinoma of uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec. 27, 1928
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Harold W. Stone, M. D.
9/30, 1929 (Address) Eastman Bldg Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	9-15 1929
20. Undertaker	Address
C. V. Peckham	Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67583

Local Registrar's No. 96

88a

2. FULL NAME Chas. Russell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Negro

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): 1875

7. AGE: Years 54 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): No. Carolina

PARENTS

10. NAME OF FATHER: Chas. Russell

11. BIRTHPLACE OF FATHER (city or town) (State or Country): No Carolina

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): No Carolina

14. Informant: Frank Allen

(Address): Pocatello Idaho

15. Filed 9-14-, 1929 John S. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1929, to Sept 9, 1929

that I last saw him alive on Sept 9, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Endocarditis & Myhrite

..... (duration) ..... yrs. several mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [signature], M.D.

9/14, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill Cemetery | Date of Burial: 9-11-29

20. Undertaker: Paul L. Lease | Address: Caldwell Ida

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67584

PLACE OF DEATH

County of Caribou
City of Soda Springs
Registration District No. 82
Primary Registration District No. 2159
Local Registrar's No. 21
(No. Caribou Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna F. Wright
(a) Residence. No. Thayne Wyo. St. Thayne, Wyo
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Wright

6. DATE OF BIRTH (month, day and year) May 7-1876

7. AGE Years 53 Months 4 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Charles Ida

PARENTS
10. NAME OF FATHER Hans J. Hemmert
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Annie K. Nielson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Mrs Tillie Robinson
(Address) Freedom Wyo.

15. Filed 9-25, 1929 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 22, 1929, to Sep 24, 1929
that I last saw her alive on Sep 24, 1929
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Pentonitis
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Ruptur J Gall Bladder an old neglected case
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? yes Date of Sep 23, 1929
Was there an autopsy? 0
What test confirmed diagnosis? ✓ X-Ray
(Signed) Elsie Kane Ly, M. D.
9-25-29, 19 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of [redacted] or Removal Thayne Wyo
Date of Burial Sept 28 - 1929

20. Undertaker E. L. Whitman
Address Soda Springs Idaho

MARGIN
WRITE PLAINLY, WITH UNFADING IN[illegible]T RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 28 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67584

Dr. Ellis Kackley
Soda Springs, Ida.

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

AUG 19 1965

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

Special Agent, Bureau of Census.

In reference to the death certificate of:
Anna F. Wright who died Sept. 24, 1929
Cause of death given as "Peritonitis" "Rupture of gall bladder."

Information DESIRED in order to complete certificate.

PLEASE STATE CAUSE OF RUPTURE OF GALL BLADDER.

PLEASE ANSWER BELOW So far as I know, an old neglected case.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67585

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. Caribou Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

117

2. FULL NAME Frances Weaver
(a) Residence. No. Soda Springs Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 3 - 1923

7. AGE Years 6 Months — Days 15 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Soda Springs Idaho

PARENTS
10. NAME OF FATHER Budd D. Weaver
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ibapah Utah
12. MAIDEN NAME OF MOTHER Josephine Copley ~~Sarah Jane Phillips~~
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Colvicton New York.

14. Informant Budd Weaver
(Address) Soda Springs Ida

15. Filed 9-18, 1929 Dr Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3, 1929, to Sept 18, 1929 that I last saw her alive on Sept. 17, 1929 and that death occurred, on the date stated above, at 1:45 a m.
The CAUSE OF DEATH* was as follows:
Acute appendicitis
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Tuberculous Peritonitis (duration) (?) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? yes Date of 9/3/29
Was there an autopsy? No
What test confirmed diagnosis? Inspection
(Signed) Russell Tigert, M. D.
Sept 18, 1929 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Soda Springs Ida. Date of Burial 9-20 1929

20. Undertaker C. D. Whitman Address Soda Springs Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67586

PLACE OF DEATH
County of Caribou
City of Soda Springs
Registration District No. 87
Primary Registration District No. 2159
Local Registrar's No. 19
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Erwin Davis

(a) Residence. No. Soda Springs Ida St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 29 1915

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	3	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Soda Springs Ida

PARENTS

10. NAME OF FATHER J. T. Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Clifton Ida
12. MAIDEN NAME OF MOTHER Alice Gunnell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wellsville Ut.

14. Informant J. T. Davis
(Address) Soda Springs Ida

15. Filed 8-31, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26, 1929, to Aug 29, 1929, that I last saw h[illegible] alive on Aug 29, 1929, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:
Peritonitis

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Ruptured Appendix
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Aug 26, 1929
Was there an autopsy? no
What test confirmed diagnosis? Operation

(Signed) [illegible] M. D.
8-31, 1929 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Soda Springs Ida — Date of Burial: Sept 1st 1929
20. Undertaker: E. Dewitzman — Address: Soda Springs Ida

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67587

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 759
(No. Caribou Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 18

2. FULL NAME Mildred Evans
(a) Residence. No. Chesterfield Ida St. Chesterfield, Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of School Girl

6. DATE OF BIRTH (month, day and year) Aug 14-1916

7. AGE Years 13 Months 1 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chesterfield Ida

PARENTS
10. NAME OF FATHER John C. Evans
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City Ut.
12. MAIDEN NAME OF MOTHER Lucy C. Loveland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Chesterfield Ida

14. Informant John C. Evans
(Address) Chesterfield Ida

15. Filed 9-18, 1929 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929, to Sept 17, 1929
that I last saw her alive on Sept 17, 1929
and that death occurred, on the date stated above, at 4:30 P m.
The CAUSE OF DEATH* was as follows:
Peritonitis
..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Ruptured appdx
..... (duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? Chesterfield, Ida
Did an operation precede death? yes Date of 9/17/29
Was there an autopsy? no
What test confirmed diagnosis? Inspection
(Signed) Ellis Kochler, M. D.
9-18, 1929 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Chesterfield Idaho Date of Burial 9-19-1929

20. Undertaker G. D. Whitman Address Soda Springs Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67588

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No. 4 B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jane L Robinson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 1 1865

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	5	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grantsville Utah.

PARENTS

10. NAME OF FATHER Andrew B Millward
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Lucy Eastham
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mable Barrus
(Address) Sugar City Idaho.

15. Filed 8-21, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1929, to Aug 4, 1929
that I last saw her alive on Aug 4, 1929
and that death occurred, on the date stated above, at 11: P m.

The CAUSE OF DEATH* was as follows:
Chronic Myocardeitis
(duration) 2 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Hugh E Dean, M. D.
Aug 6, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grantsville Utah	Aug. 8 1929
20. Undertaker D.E.Johnson	Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67589

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. 100) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eva Terry Martell

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 10, 1928

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
~~10~~	X10	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida

PARENTS

10. NAME OF FATHER Mark Martell

11. BIRTHPLACE OF FATHER (~~city~~ or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Terry

13. BIRTHPLACE OF MOTHER (~~city~~ or town) (State or Country) Utah

14. Informant Mark Martell
(Address) Burley Ida.

15. Filed Aug 18, 1929 F. H. Miller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5, 1929, to Aug 12, 1929, that I last saw her alive on Aug 12, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:-

Bronchial Pneumonia and
Pneumococcal Meningitis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

8/13, 1929 (Signed) H. O. Nelson, M. D. (Address) Burley Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
	Aug. 14 1929

20. Undertaker D. E. Johnson Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67590

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rae Cole

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Willard Ut.

PARENTS

10. NAME OF FATHER William J Cole

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Willard Utah

12. MAIDEN NAME OF MOTHER Eliza Pittingill

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Willard Utah.

14. Informant W. J. Cole
(Address) Tremonton Ida

15. Filed Aug 21, 1929 Heyburn Fick Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) D. E. Johnson Coroner, M. D.
Aug. 21 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Willard Utah.	Aug. 23 1929
20. Undertaker D. E. Johnson	Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67591

RECEIVED SEP 19 1929

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No.

Primary Registration District No.

(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Verla Mildred Butler

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept. 7, 1912

7. AGE — Years: 17 | Months: 11 | Days: 11 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Willard Utah

PARENTS

10. NAME OF FATHER: John Butler
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Hooper Ut
12. MAIDEN NAME OF MOTHER: May Beasley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill

14. Informant: Mrs John Butler
(Address) Willard Ut

15. Filed Aug 21, 19 29 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. C. Johnson Coroner M.D.
Aug 21, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hooper Ut.	Aug. 23 1929
20. Undertaker	Address
W. C. Johnson	Burley

RECEIVED OCT 9 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67592

PLACE OF DEATH

County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187

Local Registrar's No. 101

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Fremont Schenck

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
38	6	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Walter Hartness

9. BIRTHPLACE (city or town) (State or country) Fall Creek Ore

PARENTS

10. NAME OF FATHER Edwin E Schenck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) E Port Ills
12. MAIDEN NAME OF MOTHER Ida A Randall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Waterloo Iowa

14. Informant Mrs W. F. Schenck
(Address) Grangemont

15. Filed 9/26, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1929, to Sept. 25, 1929
that I last saw ~~he was~~ alive on Sept. 23, 1929
and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:
Fracture 6th Cervical vertebra. - Accidental. Struck by car overturned road grader
(duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Complete laceration of spinal cord resulting in total paralysis below the neck
(duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X-ray.
(Signed) R. J. Hoffman, M. D.
Sept. 26, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clarkston Wash	Sept 27 1929
20. Undertaker W. R. Pinson	Address Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 9 - 1929

PLACE OF DEATH

County of Clearwater

City of Ahsahka

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

DO NOT WRITE IN THIS SPACE
State File No. 67593

Local Registrar's No. 160

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Julia Kelly Surprise

9/13

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Frank Surprise

6. DATE OF BIRTH (month, day and year): Oct 1st 1854

7. AGE

Years	Months	Days	If LESS than 1 day,
74	11	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Milwaukee Wis.

PARENTS

10. NAME OF FATHER: Dr Owen Kelly
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Mary E. Cole
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N. Y.

14. Informant: Mrs. Emma Baker
(Address): Ahsahka Ida

15. Filed 9/26, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1929, to Sept 27, 1929
that I last saw her alive on Sept 23, 1929
and that death occurred, on the date stated above, at 11:25 P. m.
The CAUSE OF DEATH* was as follows:

Arterio Sclerosis.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Findings
(Signed) C. M. Busted, M. D.
Sept 25, 1929 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino	Sept 27, 1929
20. Undertaker	Address
W. D. Pinson	Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 9 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67594

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2157
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 99

2. FULL NAME Christopher S. Schnabel
(a) Residence. No. 2503 E. Main St. Lewiston - Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? 58 yrs. + mos. + ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) January 4, 1848

7. AGE

Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
81	8	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Unascertained
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed 9/26, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to September 23 1929
that I last saw him alive on September 22, 1929
and that death occurred, on the date stated above, at 6 45 A. m.
The CAUSE OF DEATH* was as follows:
General arteriosclerosis
(duration) 5 yrs. + mos. + ds.
CONTRIBUTORY (Secondary) Psychosis with cerebral arteriosclerosis (duration) 5 yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) John Irvine McKelway, M. D.
Sept. 23, 1929 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho
Date of Burial: 9/25 1929

20. Undertaker: Brower - Wann Co
Address: Lewiston Idaho

RECEIVED OCT 9 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67595

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2197
Local Registrar's No. 95
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME R. E. Wright (Robert Edward Wright) - 48B

(a) Residence. No. ... St. Troy - Idaho -
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) October 31, 1846

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	10	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Unascertained
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burnette, Wisconsin

PARENTS

10. NAME OF FATHER Larnard Wright
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Massachusetts
12. MAIDEN NAME OF MOTHER Hanna Maria VanBrunt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records, Northern Idaho Sanitarium
(Address) Orofino - Idaho

15. Filed Sept 21, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 5, 1929, to September 18 1929
that I last saw him alive on September 17 1929
and that death occurred, on the date stated above, at 7:50 A. m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Senile psychosis - Paranoid type
(duration) ? yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John Howe McKelway, M. D.
Sept. 18, 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sanitarium Cemetery -	Sept. 19 1929
20. Undertaker	Address
F. A. Billberg - Hosp. Attdr.	Orofino - Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 9 – 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67596

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 10
Primary Registration District No. 2187

Local Registrar's No. 97

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

47

2. FULL NAME May Wilcox

(a) Residence. No. Orofino St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Femal	White	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of A. E. Wilcox

6. DATE OF BIRTH (month, day and year) June 3 1870

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	3		hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS

10. NAME OF FATHER Dennis Le Courcey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Irland
12. MAIDEN NAME OF MOTHER Ella Killdal
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ny

14. Informant A. E. Wilcox
(Address) Orofino

15. Filed Sep 21 –, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19, 1928, to Sept 20, 1929
that I last saw her alive on Sept 20, 1929
and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:
Carcenoma (breast) left.
many years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Don't know
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) W. T. Robinson, M. D.
9/20, 1929 (Address) Lenore Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Colton Wash	Sep 23 19
20. Undertaker W. A. Shaw	Address Orofino

RECEIVED OCT 9 – 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67597

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2177
Local Registrar's No. 96
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Edward Vowell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Daisy Vowell

6. DATE OF BIRTH (month, day and year) Sep. 9. 1867

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62		3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Clio
(State or country) Iowa

PARENTS

10. NAME OF FATHER Lorenzo Warren Vowell

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Margaret J. Sargeant

13. BIRTHPLACE OF MOTHER (city or town) Indiana
(State or Country) Unknown

14. Informant Forest J. Vowell
(Address) Palouse Wash

15. Filed Sep. 14, 1929. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug 18, 1929, to ....., 19....
that I last saw h im alive on Aug 9th, 1929
and that death occurred, on the date stated above, at 1.55 P m.

The CAUSE OF DEATH* was as follows:
Heart - Kidneys - Toximia from Chronic Constipation
BP. 90/70 - albumin -
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Habits
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms

(Signed) W. D. Parrison, M. D.
Sept 13, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lenchwick	Sept 14 1929

20. Undertaker	Address
W D Parrison	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACT should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statemen TION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECO
MARGIN RESERVED FOR BINDING

RECEIVED OCT 9 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67598

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 2187
Primary Registration District No. 90
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 95

91B

2. FULL NAME Jarrott Ficklin

(a) Residence. No. ..... St. Coeur d'Alene, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 0 yrs. 0 mos. 24 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Ficklin

6. DATE OF BIRTH (month, day and year): Sept. 30, 1859

7. AGE: Years 69, Months 11, Days 2. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: William Ficklin
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Telna Fleece
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unascertained

14. Informant: Records: Northern Idaho San.
(Address) Orofino - Idaho.

15. Filed Sep 8, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 9, 1929, to Sept. 1, 1929
that I last saw him alive on September 1, 1929
and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:
General arterio-sclerosis
(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary): Psychosis with cerebral arterio-sclerosis (duration) ? yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) John Irvine McKelway, M. D.
Sept. 2 1929 (Address) Orofino - Idaho -

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Colfax Wash. Date of Burial: 19

20. Undertaker: [signature] Address: Orofino

...ION is very important. See instruction on back of certificate. ...OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... ...carefully supplied. AGE should be stated EXACTLY, PHYSICIANS

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67599

Registration District No. 7
Primary Registration District No. 2168
Local Registrar's No. 4

PLACE OF DEATH
County of Clearwater
City of Elk River
State of Idaho
(No. Elk River Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John M Larsan
(a) Residence No. Camp D Elk River Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
51	6	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer): Logging & Lumbering
(c) Name of employer: Potlatch Lbr Company

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ✓
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ✓

14. Informant: F A Pennington
(Address) Box 216 Elk River Idaho

15. Filed Oct 3, 19 29 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/15, 1929, to 8/27, 1929, that I last saw him alive on 8/26, 1929, and that death occurred, on the date stated above, at 6 C m.

The CAUSE OF DEATH* was as follows:
Acute dilatation of heart.
(duration) 0 yrs. 0 mos. 2 ds.
CONTRIBUTORY (Secondary) Lobar pneumonia
(duration) 0 yrs. 0 mos. 12 ds.

18. Where was disease contracted if not at place of death? Here due to exposure
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Auscultation & percussion

(Signed) Walter R. Wrellis, M. D.
8/27, 1929 (Address) Bovill, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19

20. Undertaker: E M Irwin — Address: Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25-M-11-10

RECEIVED OCT 7 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Clearwater

City of Elk River

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 91

Primary Registration District No. 2168

(No. ..... , ... St.)

File No. 67600

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cleanemis D. Barkas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Jan. (Month) 17 (Day) 1889 (Year)

7. AGE: 40 Yrs. 7 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer - Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER: Dimitrios Barkas.

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Katesini

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Barkas
(Address) Elk River, Idaho.

15. Filed Oct. 3 1929 M. Hamby Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/16/29 19..., to 8/16/29 19... that I last saw h..sist. alive on 8/16/29 19..., and that death occurred on the date stated above, at 11:55 P.M.

The CAUSE OF DEATH* was as follows: Hemorrhage from bullet wound passing thru right upper chest from front to back fracturing scapula in lower third. Shot while resisting officer.

(Duration) 0 Yrs. 0 mos. 1 ds.

Contributory (Secondary): Shock

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Walter R. Werelius M. D.

8/17 1929 (Address) Boyill, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elk River — DATE OF BURIAL: 8/19 1929

20. UNDERTAKER: Mitchell — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. RECEIVED OCT 7 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Clearwater

City of Elk River

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 91

Primary Registration District No. 2168

(No. ..... St.)

File No. 67602

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dewey E. LaVoy Jr. 48a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Jan. (Month) 20 (Day) 1922 (Year)

7. AGE: 7 Yrs. 6 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School-boy

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Dewey E. LaVoy

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Margaret ~~LaVoy~~ Veule

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Oct. 3 1929 M. Hambly Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1929, to July 1929 that I last saw h..... alive on July 1929, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) dilitation of heart

(acute) (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hyden Hancher M. D.

July 30 1929 (Address) Potlatch Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elk River, Ida DATE OF BURIAL: July 29 1929

20. UNDERTAKER: Merager ADDRESS: St. Maries, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED OCT 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67603

PLACE OF DEATH
County of Custer
City of Obsidian

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 33

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lawrence Bruce Young - 189

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day and year) Sept 4 - 1912

7. AGE: Years 17 | Months | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Scool boy.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Heggler, Ida.

PARENTS

10. NAME OF FATHER: Robert B. Young -
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Emery Co. Utah
12. MAIDEN NAME OF MOTHER: Clara Bell Palmer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Hastings, Nebr -

14. Informant: Clara Belle Young
(Address): Obsidian, Ida.

15. Filed 9-30, 1929 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19..., to ✓, 19...
that I last saw h..... alive on ✓, 19...
and that death occurred, on the date stated above, at 6:30 P m.
The CAUSE OF DEATH* was as follows: Accidentally Killed by being thrown from horse -
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Robert H. Wright - M. D.
9-6, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey Idaho | Date of Burial: Sept 8th 1929

20. Undertaker: Harris & Amos | Address: Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67604

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 74a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Keller

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Keller

6. DATE OF BIRTH (month, day and year) Apr 24 1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	5	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Peary Utah

PARENTS

10. NAME OF FATHER James Keller

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Margurett Valentine

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Hellen K. Merrill
(Address) Preston Idaho

15. Filed Oct 5, 1929 A. P. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 30, 1929
that I last saw him alive on Sept 30, 1929
and that death occurred, on the date stated above, at 4:30 p.m.
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Old Age
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Eugene Hodges M. D.
Oct 5, 1929 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Minkcreek Idaho	Oct 3 1929
20. Undertaker M. W. Hendricks	Address Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67605

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No. 27
Primary Registration District No. 2719
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elias Lyle Geddes

(a) Residence. No. 90 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Oct 25 1905

7. AGE: Years 23 | Months 10 | Days 12 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Music
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Preston

PARENTS

10. NAME OF FATHER: Joseph Geddes
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Salt Lake City Ut
12. MAIDEN NAME OF MOTHER: Isabell Dora Neely
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Brifham Utah

14. Informant: Joseph Geddes
(Address): Preston

15. Filed Sept. 11, 1929 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30, 1928, to Sept 7, 1929, that I last saw h[illegible] alive on Sept 3, 1929, and that death occurred, on the date stated above, at Midnight
The CAUSE OF DEATH* was as follows:
Rheumatic Carditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. R. Cutler, M. D.
Sept 10, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho — Date of Burial: Sept 11 1929
20. Undertaker: M. W. Hendricks — Address:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67606

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

163

2. FULL NAME Albert Smith

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 4 1912

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
17	8	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cleveland

PARENTS

10. NAME OF FATHER Nathan Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Smithfield Utah

12. MAIDEN NAME OF MOTHER Hanna Hanson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Leroy Smith
(Address) Cleveland Idaho

15. Filed 9-13, 1929. A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-8, 1929, to 9-9, 1929
that I last saw ~~him~~ alive on 9-8, 1929
and that death occurred, on the date stated above, at 12 30 ~~a~~ m.

The CAUSE OF DEATH* was as follows:
Accidental gun shot wound

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 9-8-29
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) C S Mulford M. D.
9-9, 1929 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cleveland Idaho	Sept 12 1929

20. Undertaker MW. Hendricks Address Preston Idho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67607

PLACE OF DEATH
County of Franklin
City of Clifton
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bruce Cole Cheules

(a) Residence. No. 170 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 25 1924

7. AGE	Years	Months	Days	If LESS than 1 day,
	5	7	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clifton

PARENTS

10. NAME OF FATHER Jacob H. Cheules
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Clifton Idaho
12. MAIDEN NAME OF MOTHER Ellen Cole
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Fairview Idaho

14. Informant Jacob Coules
(Address) Clifton Idaho

15. Filed 9-19, 1929 A R Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) · 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-16, 1929, to 9-17, 1929, that I last saw him alive on 9-16, 1929 and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows: Peritonitis following Abdominal injury Injured while Wrestling

Form a Hr. (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) A R Cutler M. D.
9-19, 1929 (Address) Preston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clifton Idaho	Sept 19 29

20. Undertaker M. W. Hendricks Address Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67608

PLACE OF DEATH
County of Franklin
City of Weston

Registration District No. 27
Primary Registration District No. 2119
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Hyrum Jensen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 15 1853

7. AGE Years 76 Months 4 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Carl Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Louise Jensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Louise Fife
(Address) Weston Idaho

15. Filed 9-7, 1929 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Natural death
cause unknown
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature] M. D.
M. D. Pencil Roland J. Chatterton
Bomber 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Weston Idaho
Date of Burial Aug. 5 1929

20. Undertaker M. W. Hendricks Preston Idaho
Address

RECEIVED OCT 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67609

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No.
(No.) 70-0
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clara Alberta Baird

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm. D. Baird

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	43	8	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS

10. NAME OF FATHER Ole Hogan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn.
12. MAIDEN NAME OF MOTHER Anna Hogan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn.

14. Informant Wm. D. Baird
(Address) Minkcreek Idaho

15. Filed , 19 . A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 17 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-10, 1929, to 9-17, 1929, that I last saw her alive on 9-17, 1929, and that death occurred, on the date stated above, at 4:00 a m

The CAUSE OF DEATH* was as follows:
Gen. Peritonitis
Secondary to Perforating
Appendicitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Operation for carcinoma of uterus body (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. R. Cutler, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Minkcreek Idaho	Sept 20 29

20. Undertaker	Address
M. W. Hendricks	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 28 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67609

Dr. A.R. Cutler
Preston

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentionod below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Clara Alberta Baird who died Sept. 17, 1929
Cause of death given as "Post Operative shock following Hysterectomy."
Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Carcinoma of the Uterine Body.

RECEIVED OCT 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67610

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. 6
Primary Registration District No.
Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Ross 49

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of M. A. Ross

6. DATE OF BIRTH (month, day and year) May 14 - 1851

7. AGE 78 Years Months 3 Days 26 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS
10. NAME OF FATHER John Scharen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Fugi
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant H E Bulling
(Address) Sheridan Wyo.

15. Filed 9/16, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-7-, 1929, to 9-10-, 1929
that I last saw her alive on 9-9-, 1929
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Cholelithiasis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) [illegible] M.D.
9/16, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Emmett Idaho
Date of Burial 9/16 1929

20. Undertaker C D Bucknum
Address Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 3 1929

RECEIVED OCT 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67611

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ada — Registration District No. 6

City of Emmett — Primary Registration District No. ____ — Local Registrar's No. ____

(No. ____ If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emily Matilda Cannon 131

(a) Residence. No. ____ St. ____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 18 - 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73.	3	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9. BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10. NAME OF FATHER ~~Dad~~ Gusborn Taylor

11. BIRTHPLACE OF FATHER (city or town) (State or Country) South Carolina

12. MAIDEN NAME OF MOTHER Nancy J. Kennady

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) South Carolina

14. Informant W. G. Cannon
(Address) Emmett Ida

15. Filed 9/11, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec -, 1928, to Sept 10, 1929
that I last saw her alive on July 2nd, 1929
and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:
Uremia
Fell in yard & fractured hip
old & feeble (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Fractured hip -
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) J. L. Reynolds, M. D.
9-11-, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal New Plymouth Ida — Date of Burial 9/11 1929

20. Undertaker C. D. Buckman — Address Emmett Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 27 1930

FEB 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67611

Dr. J.L. Reynolds
Emmett

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Emily Matilda Cannon who died Sept. 10, 1929
Cause of death given as "Uremia." "Fractured hip."

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AN AUTO WAS INVOLVED PLEASE NAME THE PLACE WHERE THE ACCIDENT OCCURRED

PLEASE ANSWER BELOW:

Was out in yard slipped and fell fracturing her hip she was old and feble could not get a union - She died of uremia about ten months after hip accident -

Resp yours
J. L. Reynolds M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67612

PLACE OF DEATH

County of Gem

City of Emmett

Registration District No. 6

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Robert Gross 119

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 21 - 1903

7. AGE: 26 Years, 5 Months, — Days. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ola Idaho

PARENTS

10. NAME OF FATHER: Richard Gross

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Ruth Cramer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Albert Linn
(Address) Ola Idaho

15. Filed 9/6, 1929 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30, 1929, to Sept 4, 1929 that I last saw him alive on Sept 4th, 1929 and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Typhoid Fever

(duration) yrs. mos. 17 ds.

18. Where was disease contracted if not at place of death? Gross Idaho

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J L Reynolds, M. D.

9-5-, 1929 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ola Idaho — Date of Burial: Sep. 6 1929

20. Undertaker: C D Bucknum — Address: Emmett Idaho

RECEIVED OCT 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67613

PLACE OF DEATH

County of Gooding
City of Gooding
Registration District No. 2-4
Primary Registration District No.
(No.)
Local Registrar's No. 105

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. **FULL NAME** Miles Riley

(a) Residence. No. Boise - R.4.N St. 19

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of anna Riley

6 DATE OF BIRTH (month, day and year) April 6 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Staunton
(State or country) Marion Co. Oregon.

PARENTS

10 NAME OF FATHER Charles Riley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Susan C. Sears

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Iowa.

14 Informant Mrs. G. B. Augustus
(Address) Boise Idaho

15 Filed 9/30, 1929 F. H. Cranwell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 22 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 9-20, 1929, to 9-22, 1929, that I last saw h.. alive on 9-20, 1929, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Cranwell M. D.
9/27, 1929 (Address) Fairview Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Boise Idaho	

20. Undertaker	Address
A. E. Tennyson	Gooding

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67614

PLACE OF DEATH
County of Gooding
City of Gooding

Registration District No. 24
Primary Registration District No.
(No. Gooding County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 106

2. FULL NAME Milton Ewald Lacy

(a) Residence. No. 62 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 16-1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	4	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shoshone

PARENTS

10. NAME OF FATHER E E Lacy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Maude Lillian Weiss
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Edison Neb.

14. Informant Mrs E E Lacy
(Address)

15. Filed 9/30, 1929 J H Cromwell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1929 to Sept 7 1929
that I last saw him alive on Sept 7 1929
and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Houston & Snyder M. D.
9-7, 1929 (Address) Gooding Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shoshone Ida	9-10 1929
20. Undertaker	**Address**
E E Hickox	Shoshone Ida

Form V. S. 3—5M—11-28.

RECEIVED OCT 5 _ 1929

STATE OF MONTANA
Bureau of Vital Statistics
Certificate of Death

Do not write 67615 in this space

1 **PLACE OF DEATH**

County Idaho, Registered No. 36

Township ..... or Village ..... or

City ..... No. LoLo National Forest St., ... Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 **FULL NAME** Archie White

(a) Residence. No. ....., St., ... Ward, 1889

(Usual place of abode) (If nonresident, give city or town and state)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 days. How long in U. S., if of foreign birth? 49 yrs. ..... mos. ..... days

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (Write the word.)
Male	White	Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) Dec. 1, 1877

7 AGE Years	Month	Days	If less than 1 day. hrs. or min.
52	9	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Forest fire fighter

(b) General nature of industry, business, or establishment in which employed (or employer) LoLo forest

(c) Name of employer U. S. Govt.

9 BIRTHPLACE (city or town) Sherbrook,

(State or County) Canada,

PARENTS

10 NAME OF FATHER Gregory White,

11 BIRTHPLACE OF FATHER (City or Town, State or Country) Canada,

12 MAIDEN NAME OF MOTHER Mary Albert,

13 BIRTHPLACE OF MOTHER (City or Town. State or Country) Canada,

14 Informant Felix White,

(Address) Missoula, Montana.

15 Filed 10-1, 1929 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day and year) September 1, 1929

17 I HEREBY CERTIFY, ~~[illegible]~~

~~[illegible]~~,

that ~~[illegible]~~,

and that death occurred on the date stated above, at 2p m.

The CAUSE OF DEATH* was as follows:

Fractured skull--hit by falling tree while fire fighting in LoLo National forest

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? findings

(Signed) ..... Coroner.

Sept. 3, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 Place of Burial, Cremation or Removal	Date of Burial 19
Missoula, Montana	Sept. 3 29

20 UNDERTAKER John Forkenbrock ADDRESS Missoula, Montana.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK. THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED OCT 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67616

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 2181
Local Registrar's No. 35

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jacob B Harris 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Marry Harris

6. DATE OF BIRTH (month, day and year) Aug 1 1892

7. AGE Years 36 Months 9 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lab
(b) General nature of industry, business, or establishment in which employed (or employer) Le
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Jackson Co Oregon

PARENTS
10. NAME OF FATHER Sweal Harris
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mor
12. MAIDEN NAME OF MOTHER Bowon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mor

14. Informant Oscar Harris
(Address) Grangeville

15. Filed 10-1-, 1929 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Collapsed suddenly evidently due to Organic Heart as relatives believe
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) B Chipman, M. D.
6-10-, 1929 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville
Date of Burial June 2 1929

20. Undertaker Hancock Undt. Co.
Address Grangeville Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67617

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (If death occurred in a hospital or institution, give its name instead of street and number.)

Registration District No. 30
Primary Registration District No. 1650
Local Registrar's No. 137

2. FULL NAME Marie Rabideau
(a) Residence. No. 74a 1st and Walnut St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. Rabideau

6. DATE OF BIRTH (month, day and year) 1854-9-4

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	[illegible]	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Almira N. Y.

PARENTS

10. NAME OF FATHER Frank Jeanette
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Matilda Pinckie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant Mrs Josie Norton
(Address)

15. Filed 9/28, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1929, to Sept. 23, 1929
that I last saw h[illegible] alive on Sept. 23, 1929
and that death occurred, on the date stated above, at 12 20 [illegible] m.
The CAUSE OF DEATH* was as follows:
Apoplexy - Cerebral

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chr. myocarditis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Harold J. Sturges, M. D.
9-25, 1929 (Address) C d A, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Thomas Cem. C d'Alene	9-26 1929
20. Undertaker Cassady Funeral Home	Address C d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67618

PLACE OF DEATH

County of Kootenai

City of

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 141

(No. 170)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Otto C Braun

(a) Residence. No. Dalton Gardens St. Montana

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Flossie Braun

6. DATE OF BIRTH (month, day and year) May 20, 1884

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	5	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Flossie Braun

(Address) Coeur d'Alene Ida R 7 Box 4

15. Filed 9/28, 1929 W. J. Stevens Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Gun shot wound in chest (suicide)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R B Mooney Coroner K. D.

9-20, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	9/22 1929
20. Undertaker	**Address**
R B Mooney	Box 209

RECEIVED OCT 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67619

Registration District No. 30
Primary Registration District No. 1150
Local Registrar's No. 140

PLACE OF DEATH
County of Kootenai
City of Coeur D' Alene
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John J. Smith

(a) Residence. No. 1302 Front St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 14, 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	10	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Millworker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Rutledge Timber Co.

9. BIRTHPLACE (city or town) Moston
(State or country) Wisc

PARENTS

10. NAME OF FATHER James Smith

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Wisc

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant Mrs Paul Bailey
(Address) Coeur d'Alene, Ida.

15. Filed 9/28, 1929. H. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1928, to Sept 22, 1929
that I last saw h-- alive on Sept 20, 1929
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows: Chronic Valvular Heart disease

(duration) unknown yrs. mos. ds.
CONTRIBUTORY (Secondary) High blood pressure
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Not Known
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E. H. Reed, M. D.
9-24, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	9/25 1929
20. Undertaker	Address
K. B. Mooney	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1650

DO NOT WRITE IN THIS SPACE

State File No. 67620

Local Registrar's No. 131

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth Estelle Buckingham

(a) Residence. No. 1722 - N. - 7th St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of W. Buckingham

6. DATE OF BIRTH (month, day and year) 1907 - 10 - 12

7. AGE	Years	Months	Days	If LESS than 1 day,
	21	10	27	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hayden

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER J. A. Dobson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.C.

12. MAIDEN NAME OF MOTHER Mary Dale

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.C.

14. Informant

(Address) Mary Dobson

15. Filed 9/28, 1929 H. J. Stungen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1927, to Sept 9, 1929

that I last saw her alive on Sept 9, 1929

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Harold J. Sturges, M. D.

9 - 10, 1929 (Address) C. D'A. Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest-Cem. C D'Alene	9-12 1929
20. Undertaker	Address
Carsedy Funeral Home	C D'Alene.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67622

PLACE OF DEATH
County of Kootenai
City of Near Rathdrum

Registration District No. 90
Primary Registration District No. 1050

Local Registrar's No. 142

(No. 147)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Meyers

(a) Residence. No. Wenatchee, Wash St. Wenatchee, Wn.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male ~~WXXXXX~~

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) ~~Jan~~ Nov 10, 1847

7. AGE

Years	Months	Days	If LESS than 1 day,
82	10	18	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer Saw Mill

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. Dorthy Beattiger
(Address) Wenatchee, Wn.

15. Filed 9/28, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 6:40 P m.

The CAUSE OF DEATH* was as follows:
accidently killed by auto while walking on highway Trent Road
(Neck Broken)
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) W. D. Mooney Coroner, M. D.
Oct 5, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wenatchee, Wn. — Date of Burial: Oct 6 1929

20. Undertaker W. D. Mooney Sal'd Ida — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67623

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 143

(No. 1018)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma E Olsen

(a) Residence. No. 730 - Military St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Andrew Olsen

6. DATE OF BIRTH (month, day and year) 1863 - Sept. 7

7. AGE	Years	Months	Days	If LESS than 1 day,
	66	0	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Paul Holmgren
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Mateldo Lawason
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Jennie Olson
(Address)

15. Filed 9/28, 1929. W. J. Stringer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18, 1929 to Sept 28, 1929
that I last saw h[illegible] alive on Sept 27, 1929
and that death occurred, on the date stated above, at 145 9 m.
The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam

(Signed) J. O. Dwyer M. D.
Sept 30, 1929 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C D Alene	10-2 1929
20. Undertaker	Address
Cassedy Funeral Hm	C D Alene,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED OCT 10 1929

PLACE OF DEATH

County of Kootenai

City of Coeur D' Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67624

Local Registrar's No. 144

74a

2. FULL NAME DARIUS DAY DRENNAN

(a) Residence. No. 303 Park Drive St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Blanch C. Drennan

6. DATE OF BIRTH (month, day and year): Feb. 7, 1858

7. AGE: Years 71 | Months 7 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Shelbyville Mo.

PARENTS

10. NAME OF FATHER: William Drennan

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Lucinda Cannon

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ky.

14. Informant: Mrs. Blanch C. Drennan
(Address) Coeur D' Alene, Idaho.

15. Filed 9/28, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15, 1929, to Sept 30, 1929

that I last saw him alive on ....., 19....

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

apoplexy

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

..... (duration) 2 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms tests

(Signed) P. L. McCauley, M. D.

....., 19.... (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery

Date of Burial: 10-3 1929

20. Undertaker: R. B. Mooney

Address: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67625

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 145
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Virginia C. Pierson

(a) Residence. No. 1510 - 3rd St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Jesse A Pierson

6. DATE OF BIRTH (month, day and year) 1884 - 10 - 12

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	11	23 -	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ind.
(State or country)

PARENTS

10. NAME OF FATHER — - Walters
11. BIRTHPLACE OF FATHER (city or town) Dont Know
(State or Country)
12. MAIDEN NAME OF MOTHER Rachel Henry
13. BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or Country)

14. Informant J. A. Pierson
(Address) Newport, Wash.

15. Filed 9/28, 1929 W. J. Sturgess
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 7, 1929, to October 7, 1929, that I last saw h[illegible] alive on October 7, 1929 and that death occurred, on the date stated above, at 5 45 P. m.

The ~~CAUSE~~ CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Post Falls, Idaho
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination

(Signed) Harold J. Sturgess M. D.
10-8-, 1929 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C D'Alene	10-9 1929
20. Undertaker	Address
Cassedy Funeral Home	C D'Alene.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 10 1929

PLACE OF DEATH

County of Kootenai

City of Conklin Park.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 20

Primary Registration District No. 1050

DO NOT WRITE IN THIS SPACE

State File No. 67626

Local Registrar's No. 146

(No. 1402)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Glenn Arthur Burns.

(a) Residence. No. ..... St. .....

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	~~Married~~

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1924 4-17

7. AGE	Years	Months	Days	If LESS than 1 day,
	5	5	15	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Bonners Ferry Ida.

PARENTS

10. NAME OF FATHER Jas. Burns.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Prince Edward Island. Can.

12. MAIDEN NAME OF MOTHER Mabel Dull

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mich.

14. Informant 1619 W Lake. Spokane. Wash

(Address) Mrs Gladys Clendenin

15. Filed 9/28, 1929. N. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... , 19..... to ..... , 19.....

that I last saw h— alive on ..... 19.....

and that death occurred, on the date stated above, at 3:40 P. m.

The CAUSE OF DEATH* was as follows:

Drowning

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Harold J. Sturgeon, M. D.

10-8, 1929 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Prince Edward Island. Date of Burial: Sept 30 1929

20. Undertaker: Cassedy Funeral Home Address: Coeur d'Alene

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67627

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No.
Primary Registration District No.
Local Registrar's No. 147

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vera Eleane Goodrich

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Oct 10 - 1916

7. AGE: Years 12 | Months 10 | Days 28 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Rathdrum Ida.

PARENTS

10. NAME OF FATHER: Levi L. Goodrich
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Becker Minn
12. MAIDEN NAME OF MOTHER: Phoebe Leach
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Meche. N. Dekota

14. Informant: Levi L. Goodrich
(Address): Post Falls Ida.

15. Filed 9/28, 1929. N. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19, 1929, to Sept. 8, 1929.
that I last saw her alive on Sept. 8, 1929
and that death occurred, on the date stated above, at 2.10 a. m.

The CAUSE OF DEATH* was as follows:
Osteo-Sarcoma Left Leg - (thigh)
about 8
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Frank Ware, M. D.
9/29, 1929. (Address) Rathdrum Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pine Grove Cemetery — Date of Burial: 9-10 1929

20. Undertaker: Cassedy Funeral Home — Address: Rathdrum

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67628

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 148

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Elizabeth Post

(a) Residence. No. ..... St. 129
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: A. W. Post.

6. DATE OF BIRTH (month, day and year): Aug. 25-1846

7. AGE: Years 83, Months 1, Days 1. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Plano. Ill.

PARENTS

10. NAME OF FATHER: Gilman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Do not know
12. MAIDEN NAME OF MOTHER: " " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " " "

14. Informant: J. W. Post.
(Address): Rathdrum Idaho

15. Filed 9/28, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to Sep. 26, 1929
that I last saw her alive on Sep. 25, 1929
and that death occurred, on the date stated above, at 3.15 p m.
The CAUSE OF DEATH* was as follows:
Chronic interstitial Nephritis
about 3 (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Chronic Myocarditis
about 1 (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Frank Henz, M. D.
9/27, 1929 (Address) Rathdrum, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pine Grove Cemetery
Date of Burial: 9-29 1929

20. Undertaker: Cassedy Funeral Home
Address: Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 7 1929

PLACE OF DEATH

County of Latah

City of Moscow

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 101

Primary Registration District No. 1011

(No. Inland Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67629

Local Registrar's No. 43.

119

2. FULL NAME John Conrad Stillinger

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
~~###~~ Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Etta E. Stillinger

6. DATE OF BIRTH (month, day and year) June 26, 1868

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	2	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Scuix City
(State or country) Iowa

PARENTS

10. NAME OF FATHER Conrad Stillinger

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Germany

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (city or town) " "
(State or Country)

14. Informant Mrs. Etta Stillinger

(Address) Moscow, Ida.

15. Filed Oct 2, 1929 W. H. Gauthers
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 3, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1929 to Sept 3 1929

that I last saw him alive on Sept 3rd 1929

and that death occurred, on the date stated above, at 10 a m.

THE CAUSE OF DEATH* was as follows:

Lympho-Sarcoma retroperitoneal
Mesenteric Glands.

(duration) some yrs. mos. ds.

CONTRIBUTORY (Secondary) Intest Obstruction

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 29

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Findings by Oberg made diagnosis

(Signed) E. M. Magee, M. D.

9/5, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	Ida. 9/5—1929

20. Undertaker	Address
H. R. Short	Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 7 1929

PLACE OF DEATH

County of LATAH

City of MOSCOW

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 67630

Local Registrar's No. 44

100 a

2. FULL NAME SILAS SIDNEY BONHAM

(a) Residence. No. ..... St. Spokane, Wash.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. ~~yrs.~~ ~~mos.~~ 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Odessa A. Bonham

6. DATE OF BIRTH (month, day and year): Feb. 22, 1868

7. AGE: 61 Years, Months: 6, Days: 25. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: LAND LORD

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Kansas

PARENTS

10. NAME OF FATHER: Hamilton Bonham

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Sarah M. Wolfe

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Mrs Odessa Bonham
(Address) [redacted] Spokane, Wash.

15. Filed Oct 2, 1929 W H Carithers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1929, to Sept. 17, 1929 that I last saw him alive on Sept. 17, 1929 and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia bronchial.

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Operation for Rheumatism and chronic tonsilitis ..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Sept. 12, 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Johnny Einhorn, M. D.

Sept. 18, 1929 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow Ida — Date of Burial: 9/19 1929

20. Undertaker: H. R. Short — Address: Moscow Ida

RECEIVED MAR 3 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67630

Dr. J.H. Einhouse
Moscow

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Silas Sidney Bonham who died Sept. 17, 1929
Cause of death given as "Pneumonia, Bronchial."

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Rheumatism & chronic tonsilitis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67631

PLACE OF DEATH
County of Latah
City of Troy.

Registration District No. 64
Primary Registration District No. 2144
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Florence Hupp.

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Orlander Hupp Deceased

6. DATE OF BIRTH (month, day and year): Jan 28 1855

7. AGE: Years 74 | Months 7 | Days 12 | If LESS than 1 day: ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Nashville Tenn

PARENTS

10. NAME OF FATHER: Porter Coulter
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn
12. MAIDEN NAME OF MOTHER: Mary —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn

14. Informant: Virginia Hupp
(Address): Troy Idaho

15. Filed Sept 30, 1929 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1929, to Sept. 19, 1929
that I last saw her alive on Sept. 19, 1929
and that death occurred, on the date stated above, at 8 A. m.
The CAUSE OF DEATH* was as follows:
General septicemia.
(duration) 2 yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? .....
(Signed) Chas. A. Meyer, M. D.
Sept 30, 1929. (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Little Bear Ridge cem — Date of Burial: Sept 21 1929
20. Undertaker: John J. Pickard — Address: Troy Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS ould state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-ION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67632

PLACE OF DEATH
County of Latah
City of Kendrick
Registration District No. 63
Primary Registration District No.
Local Registrar's No.
(No. 184 E)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Henry Dougharty
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 12/25/1857

7. AGE Years	Months	Days	If LESS than 1 day,
72	6	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Calif.

PARENTS
10. NAME OF FATHER — Dougharty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Mrs. G. H. Dougharty
(Address) Juliaetta Idaho

15. Filed July 19, 1929 B. F. Nesbit. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to July 18, 1929
that I last saw him alive on July 18, 1929
and that death occurred, on the date stated above, before 7 a. m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage, Tentorial tear
fractured L side Occipital bone

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. H. Tisdale, M. D.
July 18, 1929 (Address) Kendrick Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal — Date of Burial
Juliaetta Ida
American Ridge — July 21 1929

20. Undertaker — Address
Brower-Wenn Co — Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67633

PLACE OF DEATH
County of Kootenai
City of Leland
Registration District No. 63
Primary Registration District No.
(No. 129)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Marion Blankenship

(a) Residence. No. (Usual place of abode) Street 28 yrs (If nonresident give city or town and State)
Length of residence in city or town where death occurred: yrs. mos. ds. How long in U. S., if of foreign birth? X yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Sept 13 1855

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	10	15	X hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Worked for Self
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) St Joseph Miss

PARENTS

10. NAME OF FATHER Jesse Blankenship
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Elizabeth Kerns
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Raymond Blankenship
(Address) Leland, Ida.

15. Filed July 30, 1929 B. F. Nesbit. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 29th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17th, 1929, to July 29, 1929, that I last saw h[illegible] alive on July 26, 1929, and that death occurred, on the date stated above, at 9 P.M. 12 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
for Several yrs-
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis Heart disease
Several yrs
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Urinary test etc

(Signed) Russell Truitt, M. D.
July 30, 1929 (Address) Smithwick

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cameron Cemetery Leland — Date of Burial: July 31 1929

20. Undertaker: J. J. Pickerd — Address: Post, Ida.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 25 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Kendrick

Registration District No. 63

Primary Registration District No.

(No. ..... St.)

File No. 67634

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Franklin Waltz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH. Jan (Month) 24 (Day) 1859 (Year)

7. AGE 70 Yrs. 7 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Barbour Wis.

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs David Waltz

(Address) Kendrick Ida

15. Filed Sept 10 1929 B. F. Nesbit Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 74a Sept. (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1929, to Sept. 9 1929, that I last saw him alive on Sept. 9 1929, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. H. Field M. D.

Sept 9 1929 (Address) Kendrick, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kendrick Ida

DATE OF BURIAL: Sept. 12 1929

20. UNDERTAKER: Wm J Pickerd

ADDRESS: Troy Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO. PTRS. & BORS. 24854

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

PLACE OF DEATH

County of Latah

City of Pollatch

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 65

Primary Registration District No. 2145

DO NOT WRITE IN THIS SPACE

State File No. 67635

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eliza Harriett Miller

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

45

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 73 Months 6 Days 18 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER L Burden

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Sarah Eades

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Ester E. Jordan

(Address) Spokane Wash

15. Filed Sept 10th, 1929 Dr. Mr. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 31, 1929

that I last saw him alive on July, 19

and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Intestines

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. C. Gibson, M. D.

Sept. 10th, 1929 (Address) Pollatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Freeze Cemetery

Date of Burial Sept 11 1929

20. Undertaker J. M. Irwin

Address Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67636

PLACE OF DEATH
County of Latah
City of Pottaleh

Registration District No. 6 5
Primary Registration District No. 2145
(No. Western Hospital Association Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Hanner Lemon Cochrane

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Cochrane,

6. DATE OF BIRTH (month, day and year) 1893 Apr 1

7. AGE	Years	Months	Days	If LESS than 1 day,
	36	5	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hook Tender
(b) General nature of industry, business, or establishment in which employed (or employer) Loading Togt
(c) Name of employer Pottaleh Lum Co

9. BIRTHPLACE (city or town) (State or country) Princeton Ida

PARENTS

10. NAME OF FATHER George Thomas Cochrane
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Novascotia
12. MAIDEN NAME OF MOTHER Orpha Chambers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant James A. Cochrane
(Address) Princeton Idaho.

15. Filed Sept 4th, 1929 Dr. J.W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:
Accidental Compound fracture of the right thigh & knee
Run over by engine in Logging operations in woods for Pottaleh Lbr. Co (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Shock & hemorrhage
... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? yes. Date of Sept 4th 1929
Was there an autopsy? No.
What test confirmed diagnosis? ...
(Signed) J.W. Thompson, M. D.
Sept 5th, 1929. (Address) Pottaleh.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Palouse Wash	Sept 8 1929
20. Undertaker E M. Irwin	Address Palouse Wash.

RECEIVED MAR 3 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67636

Dr.J.W. Thompson
Potlatch, Ida.

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Hamer Lemon Cochrane who died Sept. 4, 1929
Cause of death given as "accidental compound fracture of the rt. thigh and knee."

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH? IF AN AUTO WAS INVOLVED PLEASE NAME THE PLACE WHERE THE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Hamer Lemon Cochrane, was run over by a train log during logging operations in the woods for the Potlatch Lumber Co

Yours J W Thompson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 25 1929

PLACE OF DEATH

County of Latah

City of Pottatch

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67637

Registration District No. 65

Primary Registration District No. 2145

Local Registrar's No. 65a

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louise Parker

(a) Residence. No. Pottatch St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: O S Parker

6. DATE OF BIRTH (month, day and year): Apr 14/1854

7. AGE: Years 75 Months 4 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Chicago Ill.

PARENTS

10. NAME OF FATHER: Clark

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Frances Flasher

(Address): Pottatch Idaho

15. Filed Aug. 21, 19.. Dr J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan., 1928, to Aug. 18th, 1929 that I last saw her alive on Aug. 10th, 19.. and that death occurred, on the date stated above, at 4.30 p m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leucocythemia

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) F. C. Gibson M. D.

Aug. 21st, 1929 (Address) Pottatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pottatch Ida

Date of Burial: Aug 21 1929

20. Undertaker: E M Irwin

Address: Palouse Wash

Oct.

RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67638

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 6 5
Primary Registration District No. 2145
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Kilburn

(a) Residence. No. Potlatch Western Hospital Association
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 21. 1925

7. AGE

Years	Months	Days	If LESS than 1 day,
3	10	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Palouse Wash.
(State or country)

PARENTS

10. NAME OF FATHER J H Kilburn
11. BIRTHPLACE OF FATHER (city or town) Mich
(State or Country)
12. MAIDEN NAME OF MOTHER Mable Moore
13. BIRTHPLACE OF MOTHER (city or town) Ill.
(State or Country)

14. Informant J. H. Kilburn
(Address) Palouse Wash.

15. Filed Sept. 3 1929 Jas. Thompson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug. 20th, 1929, to Sept. 2nd, 1929
that I last saw him alive on Sept. 2nd, 1929
and that death occurred, on the date stated above, at 4:30 P. m.
The CAUSE OF DEATH* was as follows:

Accidental Scald with boiling water.

(duration) yrs. mos. 13 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? ✓

(Signed) Jas. Thompson, M. D.
Sept 3rd, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Palouse Wash.	Sept 4 1929

20. Undertaker E. H. Truin - Palouse Wash. Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. [illegible] 1-19

RECEIVED SEP 25 19[illegible]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65

Primary Registration District No. 2145

File No. 67639

Registered No.

1. PLACE OF DEATH

County of Latah.

City of Potlatch

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donald Jerome Clifford.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male.	White	single.

6. DATE OF BIRTH: Aug. (Month) 27 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 13 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Potlatch

10. NAME OF FATHER: Carl. Adam. Clifford.

11. BIRTHPLACE OF FATHER (State or Country): Waverly. Wash.

12. MAIDEN NAME OF MOTHER: Beatrice Thea. Hallestad.

13. BIRTHPLACE OF MOTHER (State or Country): Madison. - Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl. A. Clifford.

(Address) Potlatch

15. Filed Sept. 9th 1929 J. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 9th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1st 1929, to Sept. 9th 1929, that I last saw h[illegible] alive on Sept. 8. 1929 and that death occurred on the date stated above, at 4-45 A.M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) ✓

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Thompson M. D.

9/9/1929 (Address) Potlatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Potlatch — DATE OF BURIAL: Sept. 10th 1929

20. UNDERTAKER: Parents. — ADDRESS: Potlatch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 25 1929

PLACE OF DEATH

County of Latah

City of Potlatch

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 65

Primary Registration District No. 2145

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67641

Local Registrar's No. .....

131

2. FULL NAME Edman North Billows.

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 19. 1885

7. AGE: Years 44 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mich

PARENTS

10. NAME OF FATHER A. J. Billows.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich

12. MAIDEN NAME OF MOTHER Hattie Benzeter

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mich

14. Informant H. R. Billows.

(Address) Boville Ida.

15. Filed Sept 9th, 1929. J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30th, 1929, to Sept 8th, 1929

that I last saw him alive on Sept 8th, 1929

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous abscess of Left Kidney.

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Coeur d'Alene, Wash

Did an operation precede death? No Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Jos. Thompson, M. D.

9/9/ 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Potlatch Wash. | Date of Burial: Sept 11 1929

20. Undertaker: C. M. Crain Potlatch Wash. | Address

RECEIVED SEP 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67642

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No.) 44
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Jasper Newton Gilium
(a) Residence (Usual place of abode) No. Salmon St. (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chloe Rebecca
6. DATE OF BIRTH (month, day and year) Jan. 1st, 1863
7. AGE Years 66 Months 8 Days 3 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Berryville, Ark.

PARENTS
10. NAME OF FATHER Marion Francis Gilium
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Elizabeth Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn

14. Informant Mrs. J. H. Gilium
(Address) Salmon Ida.
15. Filed Sept 10, 1929. Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 3 (Month) (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug. 26, 1929, to Sept 3, 1929
that I last saw him alive on Sept 3, 1929
and that death occurred, on the date stated above, at 11 35 A m.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach
About (duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No —
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
Sept 3, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salmon Cemetery
Date of Burial Sept 4th 1929
20. Undertaker Wm C Hackler
Address Salmon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67643

PLACE OF DEATH
County of Lemhi
City of Salmon
Registration District No. 47
Primary Registration District No. 2116
(No.) 1018
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alvin Andrews

(a) Residence. No. St. Fall River, Wisconsin
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 45 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of married Mary V. Andrews

6. DATE OF BIRTH (month, day and year) Jan. 20, 1848

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	7	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Grain and feed
(c) Name of employer himself

9. BIRTHPLACE (city or town) (State or country) Union, New York

PARENTS

10. NAME OF FATHER Lyman Andrews
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Union, N.Y. New York
12. MAIDEN NAME OF MOTHER Sally Young
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Straussburg Germany

14. Informant Mary V. Andrews Widow of Deceased
(Address) Fall River, Wisconsin

15. Filed 9/28, 19 Chas F Hammer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 27th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1929, to Aug 27, 1929
that I last saw her alive on Aug 27, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Pneumonia - (Hypostatic)

(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Fracture of femur

(duration) yrs. mos. 19 ds.
Cholecystitis several months
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
Aug 29, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

Place of Burial, Cremation, or Removal	Date of Burial
Fall River, Wis	19

20. Undertaker J M C Hoobler Address Salmon Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67644

PLACE OF DEATH
County of Lemhi
City of Lemhi Idaho

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stella Starr

46

(a) Residence. No. Lemhi Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 30th 1888

7. AGE Years 41 Months 4 Days 9 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Henry Grush
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Arthur Starr
(Address) Lemhi Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 9th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21, 1928, to July 29, 1929
that I last saw her alive on July 29, 19
and that death occurred, on the date stated above, at 1-40A m.
The CAUSE OF DEATH* was as follows:
Cancer of uterus

About 2 years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical - & labs
(Signed) Chas F Hammer, M. D.
Aug. 15, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salmon Cemetery
Date of Burial 8/10/1929

20. Undertaker Jim C. Toebler
Address Salmon Ida

RECEIVED SEP 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67645

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 7
Primary Registration District No. 2116
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. ....

1016

2. FULL NAME Peter Mitchell

(a) Residence. No. St. Cloud, Minn. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	not known

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day Labor
(b) General nature of industry, business, or establishment in which employed (or employer): Road Construction
(c) Name of employer: not known

9. BIRTHPLACE (city or town) (State or country) ~

PARENTS

10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: Wm C Doebler
(Address): Salmon Ida.

15. Filed Aug 17, 1929 Clio Williams Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 7th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1929, to Aug 7, 1929
that I last saw h[illegible] alive on Aug 7, 1929
and that death occurred, on the date stated above, at 9 - 0 - m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(unilateral)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? North Fork Idaho
Did an operation precede death? No Date of ....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
Aug 12, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	8/8/1929
20. Undertaker	Address
Wm C Doebler	Salmon, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67646

PLACE OF DEATH
County of Madison
City of Sugar City

Registration District No. 100
Primary Registration District No. 278
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 65

2. FULL NAME Martha Haynes Stephens 92

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Sam Stephens

6. DATE OF BIRTH (month, day and year) June 12 - 1889.

7. AGE Years 40 Months 2. Days 28. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Amba. Kentucky

PARENTS

10. NAME OF FATHER Clell. Haynes

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Amba. Kentucky

12. MAIDEN NAME OF MOTHER Polly Jane Sturgell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant S. B. Stephens
(Address) 1316 Phillips St. Missoula. Mont

15. Filed 9/16, 1929 J Ryoung Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 10, 1929
that I last saw her alive on Sept 10, 1929
and that death occurred, on the date stated above, at 3 15 a m.
The CAUSE OF DEATH* was as follows:
Pulmonary Embolism
Gangrene of leg due to embolism.
(duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Obesity.
(duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? Yes Date of July - 1929 (mo)
Was there an autopsy? no
What test confirmed diagnosis? symptoms
(Signed) Louis L. Rich, M. D.
9/12, 1929 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sugar City. Ida. Date of Burial 19

20. Undertaker Vern J. Keller Address Rexburg.

RECEIVED MAR 3 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67646

Dr. L.F. Rich
Rexburg

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Martha Haynes Stephins who died Sept. 10, 1929
Cause of death given as "Pulmonary embolism." "Obesity."

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED

PLEASE ANSWER BELOW: Rexburg Idaho 2/27/30

Gangrene of leg due to embolism.
operation by C M Cline MD Idaho Falls Idaho
a few months before patient died

Louis F. Rich
Rexburg Idaho

FORM V. S. REG. MV 1-10 SEP 18 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 67647
Local Registrar's No. 64

1. PLACE OF DEATH
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lorena Flamm

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Sept. (Month) 9 (Day) 1871 (Year)

7. AGE: 57 Yrs. 11 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wells-Ville Utah

10. NAME OF Father: James Eckersell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Henrietta McFail

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H.J.Flamm
(Address) Rexburg Idaho

15. Filed [redacted] 9/16 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1929, to Aug 30 1929, that I last saw her alive on Aug 29 1929, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma.
(Uterine)

(Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary) Anemia

(Duration) 1 yrs. 6 mos. ..... ds.

9/1 (Signed) Lorin F. Rich M. D.
1929 (Address) Rexburg Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg Cemetery
DATE OF BURIAL: 10/2 1929

20. UNDERTAKER: A.B. Eckersell
ADDRESS: Rexburg Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 18 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Madison
City of Lyman
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 67648
Registered No. 63

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harlet Gilquist Clark McDaniel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: June (Month) 27 (Day) 1881 (Year)

7. AGE: 48 Yrs. 1 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Grass Creek. Utah.

10. NAME OF FATHER: Ellick. Gilquist.

11. BIRTHPLACE OF FATHER (State or Country): Scotland.

12. MAIDEN NAME OF MOTHER: Agnes. Poter.

13. BIRTHPLACE OF MOTHER (State or Country): Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ambrose McDaniel
(Address) Thornton Idaho

15. Filed 9/16 1929
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 10 (Day) 1929 (Year) 90

17. I HEREBY CERTIFY, That I attended deceased from July 24 1929, to Aug 8 1929
that I last saw her alive on July 8 1929
and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:
Cardio vascular renal disease

(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Chronic nephritis

(Duration) ..... Yrs. 2 mos. ..... ds.

(Signed) Lorin F. Rich. M. D.
8/13 1929 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lyman Idaho. DATE OF BURIAL: Aug. 14 1929

20. UNDERTAKER: Leon F. Kellis ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67649

PLACE OF DEATH

County of Nezperce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009

Local Registrar's No.

(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

136

2. FULL NAME Walter Anderson

(a) Residence. No. Lewiston, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	38	7	22	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hardware Man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tennesee

PARENTS

10. NAME OF FATHER Harris Anderson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Effie Cochrane

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Mrs. Walter Anderson
(Address)

15. Filed Aug 25, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July, 2nd. 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to July 2, 1929
that I last saw h~~im~~ alive on July 2, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

acute Peritonitis (General)
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis
Gangrenous (duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 29 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Ed Broadbent, M. D.

Aug 17, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Lewiston, Ida. Normal Hill	7/5/1929
20. Undertaker	Address
Brower-Vann Co., Lewiston, Ida.	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67650

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1099
Local Registrar's No.
(No. 719 - 20th St)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1098

2. FULL NAME James Ira Litchfield

(a) Residence. No. 719 - 20th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 25th 1900.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28	8	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Round House Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Camas Prairie R.R. Co.

9. BIRTHPLACE (city or town) (State or country) Milan Mo.

PARENTS

10. NAME OF FATHER Chas N. Litchfield
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dowdyville N. Y.
12. MAIDEN NAME OF MOTHER Belle Yardley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Okla.

14. Informant Chas N. Litchfield.
(Address) Lewiston Idaho.

15. Filed Aug 25, 1929 Susan E Burns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-28, 1929, to 7-1, 1929
that I last saw him alive on 7-1, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Septic sore throat.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Haemolytic Streptococcus septicaemia

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M. D.
7/1, 1929 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	7/3 1929
20. Undertaker	Address
Brower-Wann Co	Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

#17

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67651

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

135

2. FULL NAME E. R. White

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept. 27-1863

7. AGE: 65 Years, Months: 9, Days: 21 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: City Employee
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer: City of Lewiston, Idaho.

9. BIRTHPLACE (city or town) (State or country): Old Town Maine

PARENTS

10. NAME OF FATHER .....
11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....
12. MAIDEN NAME OF MOTHER .....
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant: Earl White
(Address): Lewiston Idaho.

15. Filed Aug 25, 1929 Dixon E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1929 to July 18, 1929
that I last saw him alive on July 16, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Typhoid post operation
Prostatectomy
..... (duration) ..... yrs. 2 mos. ..... ds.
CONTRIBUTORY (Secondary): Prostatic hypertrophy
..... (duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? Yes. Date of May 12-1929
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) L. Stockslager, M. D.
7/21, 1929 (Address) Lewiston Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. — Date of Burial: 7/21 1929

20. Undertaker: Brower-Wann Co — Address: Lewiston, Idaho.

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67652

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

117

2. FULL NAME Fern Lorraine Calder

(a) Residence. No. 1812 - 13th Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 3rd 1926.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	7	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Enterprise Oregon.

PARENTS

10. NAME OF FATHER J. E. Calder
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City Utah.
12. MAIDEN NAME OF MOTHER Bernice Morgan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash.

14. Informant J. E. Calder
(Address) Lewiston Idaho.

15. Filed Aug 25, 1929 Brian E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13, 1929 to July 17, 1929
that I last saw her alive on July 16, 1929
and that death occurred, on the date stated above, at 1a m.
The CAUSE OF DEATH* was as follows:
Appendicitis
(duration) yrs. mos. 6 ds.
CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical symptoms
(Signed) Paul D Johnson M. D.
7/18, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	7/18 1929

20. Undertaker Brower-Wann Co. Address Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 23 1929

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

(No. 1424 10th, Ave.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67653

Local Registrar's No.

740

2. FULL NAME. Mary M Ready.

(a) Residence. No. 1424 10th, Avenue. ~~XSX~~

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Divorced.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 22nd, 1886.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43.	1.	13.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Louis, Missouri.

PARENTS

10. NAME OF FATHER Thomas B. Martin.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.

12. MAIDEN NAME OF MOTHER Bridget Burke.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland.

14. Informant Mrs Lee Strickfaden

(Address) Lewiston, Idaho.

15. Filed Aug 25, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 5th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5th, 1928 to July 5th, 1929

that I last saw her alive on July 5th, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis, Arterial Hypertension (duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observed

(Signed) L D Stockslager, M. D.

7/6/29., 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	7/8/29. 19

20. Undertaker	Address
Brower-Mann Company,	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67654

1 PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. St. Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

60 A

2. FULL NAME James W. Edwards

(a) Residence. No. 157 E. St. Court St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Addie Edwards

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Nathan Edwards

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Mary Lewis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Addie Edwards

(Address) Lewiston Idaho

15. Filed Aug 27 1929 Susan E Burr Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1929, to July 29, 1929, that I last saw h[illegible] alive on July 29, 1929, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Esophthalmic Goiter

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Metabolism + 37

(Signed) Ed Broadbent, M. D.

July 30, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Genessee Idaho	19
20. Undertaker	**Address**
Vassar Mortuary Inc.	Lewiston Ida

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67655

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. White Hospital)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Beulah Lucille Scott

(a) Residence. No. 623 - 12th St. Clarkston Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: J. W. Scott

6. DATE OF BIRTH (month, day and year): 1/16/1907

7. AGE: Years 22 | Months 6 | Days 14 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Rathdrum, Idaho.

PARENTS

10. NAME OF FATHER: James W. Sylvester.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Edwardsville, Illinois.
12. MAIDEN NAME OF MOTHER: Rosa Shoemaker.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois.

14. Informant: J. W. Scott
(Address) Clarkston, Wash.

15. Filed Aug 25, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11, 1929, to July 30, 1929 that I last saw her alive on July 29, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Pulmonary T. B.
(duration) 1 yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Same
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White. M. D.
7/31, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston — Date of Burial 19

20. Undertaker: Brower-Mann Co — Address Lewiston, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

W. O. Clark.

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67656

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital)
Local Registrar's No. 179
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert William Platt
(a) Residence. No. Genesee Idaho St. Genesee Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. / mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 20 1927

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	1	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS
10. NAME OF FATHER Will Platt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Genesee Idaho.
12. MAIDEN NAME OF MOTHER Opal Baker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Will Platt
(Address) Genesee

15. Filed Aug 25, 1929 Irma E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1929, to July 26, 1929
that I last saw h[illegible] alive on July 26, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Extreme burns of body & left arm
Child was playing with matches and clothing caught fire
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) General Septicemia
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? [illegible]
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W O Clark, M. D.
July 29, 1929 (Address) Juniper Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho.	July 28 1929

20. Undertaker Vassar Mortuary Inc. Address Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 3 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67656

Dr. W.O. Clark
Lewiston

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Robert Wm. Platt who died July 26, 1929
Cause of death given as "Extreme burns of body and left arm."

Information DESIRED in order to complete certificate:

WAS A BURNING BUILDING INVOLVED?

PLEASE ANSWER BELOW:

No.
Child was playing with matches & set clothing on fire

W O Clark MD

RECEIVED SEP 23 1929

Broadstock.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67657

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

748

2. FULL NAME Bertha Elena Wood

(a) Residence. No. 628 - 11th Ave St
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of E. J. Wood.

6. DATE OF BIRTH (month, day and year) 12/8/1888.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40	7	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Georgia.

PARENTS

10. NAME OF FATHER R. L. Howell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgia
12. MAIDEN NAME OF MOTHER Lela Wilson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Georgia.

14. Informant E. J. Wood
(Address) Lewiston Idaho

15. Filed Aug 25, 1929 Susan E. Brem Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1929, to July 26, 1929
that I last saw h[illegible] alive on July 26, 1929
and that death occurred, on the date stated above, at 1159 A m.
The CAUSE OF DEATH* was as follows:

Cerebral Embolism

..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Uterine Fibroids
..... (duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? yes Date of July 24 1929
Was there an autopsy? no
What test confirmed diagnosis? none

(Signed) Elgin Broadstock, M. D.
7/27, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clarkston Wash	7/28 1929

20. Undertaker Brown-Wann Co. Address Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67658

PLACE OF DEATH
County of Nez Perce
City of Near Uniontown or
Registration District No. 95
Primary Registration District No. 1009
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dominico Michels

(a) Residence. No. Near Uniontown or St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 22 1863

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) General Farming
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Luxenburg

PARENTS

10. NAME OF FATHER Nichols Michels
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Luxenburg
12. MAIDEN NAME OF MOTHER Margaret Thiel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Luxenburg

14. Informant John Michels
(Address) Uniontown Ida

15. Filed Aug 28, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27, 1929, to July 4, 1929, that I last saw h[illegible] alive on July 4, 1929, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? –
Did an operation precede death? No Date of –
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination

(Signed) Walter A Berg, M. D.
July 5, 1929 (Address) Uniontown Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Uniontown — Date of Burial July 6 1929

20. Undertaker Vassar Mortuary Co — Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67659

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 95
Primary Registration District No. 1809
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

748

2. FULL NAME Leander D. Cox

(a) Residence. No. Main St. Lewiston
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Alice J. Cox

6. DATE OF BIRTH (month, day and year) June 4 - 1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Joseph Cox
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Virginia Jenkins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Kingdon

14. Informant Virginia Cox
(Address) Lewiston Idaho

15. Filed Aug 25, 1929 Susan E. Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29th, 1929, to July 4th, 1929, that I last saw him alive on July 3rd, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hemaplegia 6 (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemmorhage 6 (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No What test confirmed diagnosis? Clinical Symptoms
(Signed) C. C. Cearagan, M. D.
7/8, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Lewiston Ida	
20. Undertaker	Address
Vassar Mortuary	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 23 1929

PLACE OF DEATH

County of Nez Perce

City of Lewiston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67660

Registration District No. 95

Primary Registration District No. 1009 2193

Local Registrar's No.

(No. N. Lewiston)

(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Oliver Jones.

(a) Residence. No. N. Lewiston St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Jones.

6. DATE OF BIRTH (month, day and year) Oct 30 1858

7. AGE Years 70 Months 8 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER ~~Oliver~~ Jones -

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Kate Jones

(Address) N. Lewiston

15. Filed Aug 25, 1929 Susan E Brun Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1929, to —, 19

that I last saw h— alive on 19

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ch. Inst. Nephritis

(duration) yrs. 10 mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? History

(Signed) William P. H. Habel, M. D.

July 22, 1929 (Address) Lewiston - Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho. Date of Burial July 22 1929

20. Undertaker Passar Mortuary Address Lewiston

#13

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67661

PLACE OF DEATH

County of Nez Perce

City of Zaza (Near)

Registration District No. 95

Primary Registration District No. 1009 2193

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

188 e

2. FULL NAME Richard F. Rademsky

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 60 Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stockman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mrs Roy Small
(Address) Lewiston, Idaho

15. Filed Aug 25, 1929 Susan E. Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 20th (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Crush Chest.

Auto Acc'd

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C M Brown Coroner, M. D.

7/25, 1924 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho

Date of Burial 7/25 1924

20. Undertaker Trower-Wann Co

Address Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67662

PLACE OF DEATH

County of Nezperce
City of Lewiston, Idaho

Registration District No. 95
Primary Registration District No. 1009
Local Registrar's No.
(No. Snake River)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Earl Wilford Greer

(a) Residence. No. Melrose, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
15	5	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Melrose

PARENTS

10. NAME OF FATHER Harry Greer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Luey Mc.Farland

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sedalia, Mo.

14. Informant Harry Greer
(Address)

15. Filed Sept 8, 1929 Susan E Brau Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 5th. 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Accidental Drowning

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E M Brower Coroner M.D.
8/9, 1929 (Address) Lewiston Idaho
Acting for Mr. Goodrich

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Melrose, Idaho.	Aug. 11, 1929

20. Undertaker	Address
Brower - Mann Co.,	Lewiston, Idaho.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67663

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 95
Primary Registration District No. 1009 2193
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME John Jacob Dares

(a) Residence No. St. Upper Tammany
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Nov 6 1850

7. AGE

Years	Months	Days	If LESS than 1 day,
78	8	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER —
11. BIRTHPLACE OF FATHER (city or town) (State or Country) —
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant: Mrs. W. F. Schwandt
(Address) Lewiston Idaho

15. Filed Aug 19 Burl Sept 8 29
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to Aug 5, 1929, that I last saw him alive on Aug 5 1929, and that death occurred, on the date stated above, at 6:25 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Paralysis

(Signed) D. E. Cannon, M. D.
8/7/29, 19 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pendleton Oregon — Date of Burial 19
20. Undertaker: Brewer Mann Co — Address: Lewiston Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67664

PLACE OF DEATH
County of Nez Perce
City of near Lewiston

Registration District No. 95
Primary Registration District No. 2145

Local Registrar's No.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Georgine Elizabeth Riggs

(a) Residence. No near Lewiston St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 4 1915

7. AGE	Years	Months	Days	If LESS than 1 day,
	14	----	5	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS

10. NAME OF FATHER Geo. SS Riggs
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER B. Thiessen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Geo S Riggs
(Address) Lewiston Idaho

15. Filed Sept 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15, 1929, to Aug 9, 1929,
that I last saw her alive on May 25, 1929,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis.
(duration) 1 yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) Same
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Cardinal Symptoms
(Signed) L. L. White M. D.
9-10, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	Aug 12 1929
20. Undertaker	**Address**
Vassar Mortuary Inc.	Lewiston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67665

Local Registrar's No.

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME May Bosco

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Indian
5. Single, Married, Widowed, or Divorced (write the word):
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓
6. DATE OF BIRTH (month, day and year):
7. AGE: Years: no age | Months: | Days: | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10. NAME OF FATHER: Chief White Eagle
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: May Bosco
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Sisters of St Joseph
(Address)

15. Filed Sept-8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 7 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from aug 7, 1924, to aug 7, 1924
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH was as follows:
Stillborn
(about 6½ mo)
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): unknown
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) W O Clark, M. D.
8/7, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lapwai Idaho	Aug 8 1929
20. Undertaker: Dassan Mortuary	Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

White

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67666

PLACE OF DEATH

County of Nezperce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Horace Maynard Brown

(a) Residence. No. Clarkston, Wash. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 45 Years | Months: 1 | Days: 26 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bloomington, Ill.

PARENTS

10. NAME OF FATHER: Wiley Leymony Brown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wheeling, W.V.

12. MAIDEN NAME OF MOTHER: Lettie A. Brown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Laybrook, Ill.

14. Informant: Mrs. Horace Brown
(Address)

15. Filed Sept 8, 19__ Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 1st. 1929. 19__
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1929, to Aug 1st, 1929 that I last saw him alive on Aug 1st, 1929 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows: Badly fractured + crushed skull — 4 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Accidental Fall from scaffolding on building)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation.

(Signed) E. L. White, M. D.

9-10, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Normal Hill | Date of Burial: Aug.4,1929 19

20. Undertaker: Brower-Wann Co. Lewiston, Idaho. | Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67667

PLACE OF DEATH

County of Nezperce
City of Lewiston, Idaho.
Registration District No. 96
Primary Registration District No. 1
Local Registrar's No.
(No. 7091/2 - Snake River Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucy A. Mitchell

(a) Residence. No. 7091/2 - Snake River Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	56	2	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ky.

PARENTS

10. NAME OF FATHER John Pucket
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant J. B. Mitchell
(Address)

15. Filed Sept 8, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 8, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Aug 8, 1929
that I last saw her alive on Aug 8, 1929
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Interstitial Nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W O Clark, M. D.
Aug 9, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho. Normal Hill	8/11/29 19

20. Undertaker	Address
Brower - Mann Co.,	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67668

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Chas. Patrick Whalen

(a) Residence. No. ... St. Genesee, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia A. Whalen

6. DATE OF BIRTH (month, day and year) Dec. 8, 1889

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
39	7	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Banker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Genesee Exchange Bank

9. BIRTHPLACE (city or town) (State or country) ######## Cheney ######## Wash.

PARENTS

10. NAME OF FATHER Chas? P. Whalen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Toronto Canada
12. MAIDEN NAME OF MOTHER Wineferd Leveque
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Toronto Canada

14. Informant ### L.L. Whalen
(Address) Lewiston, Idaho

15. Filed Sept 6, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 5, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to Aug 5, 1929
that I last saw him alive on Aug 5, 1929
and that death occurred, on the date stated above, at 8:95 P m.
The CAUSE OF DEATH* was as follows:
Perforated Gastric Ulcer
Diffuse Peritonitis

(duration) ... yrs. ... mos. 13 ds.
CONTRIBUTORY (Secondary) Myocardial Failure
(duration) ... yrs. ... mos. 5 ds.

18. Where was disease contracted if not at place of death? Genesee, Idaho
Did an operation precede death? Yes Date of July 22
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) E. T. Scott, M. D.
8/7, 1929 (Address) Lewiston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Genesee, Ida.	8/8/29 19

20. Undertaker F. R. Short — Address Moscow

RECEIVED SEP 23 1929

Johnson

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67670

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1005
(No. 1842 Carson Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

41

2. FULL NAME Edward A Rawson

(a) Residence. No. 1842 Carson Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ida Rawson

6. DATE OF BIRTH (month, day and year): Feb. 26 1853

7. AGE: Years 76 | Months 5 | Days 29 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Sawmill Man.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Phil. Rawson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Miranda Rawson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill.

14. Informant: Mrs Euclid Cady
(Address): Lewiston Idaho

15. Filed ____, 19____. ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1929, to Aug 24, 1929, that I last saw him alive on Aug 20, 1929, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:
Septicemia due to Chronic cystitis + catheterization.
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary): Chronic prostatitis
(duration) 4 years yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Paul B Johnson, M. D.
8/26, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nezperce Cemetery — Date of Burial: Aug 26 1929
20. Undertaker: Lewiston Idaho — Address: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67671

Local Registrar's No.

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1951
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Ward

(a) Residence. No. Culdesac St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds.

Culdesac Idaho
(If nonresident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mary C Ward.

6. DATE OF BIRTH (month, day and year): April 6 1887

7. AGE: Years 42 | Months 4 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Service Station
(b) General nature of industry, business, or establishment in which employed (or employer): Owner
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ore.

PARENTS

10. NAME OF FATHER: James T. Ward
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ore.
12. MAIDEN NAME OF MOTHER: Dorothy Gorley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ore.

14. Informant: Mary C Ward
(Address): Culdesac Idaho

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1929, to Aug 21, 1929
that I last saw him alive on Aug 21, 1929
and that death occurred, on the date stated above, at 5:15 P m.

The CAUSE OF DEATH* was as follows:
Fractured Vertebrae with
cord injury
Shock - Multiple Bruises
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Automobile accident on
Highway near Culdesac, Ida
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of Aug 21
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) R. T. Scott, M. D.
Aug 22, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho — Date of Burial: Aug 24 1929
20. Undertaker: Vassar Mortuary — Address: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 3 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67671

Dr. R.T. Scott
Lewiston

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

C.E. Ward who died Aug. 21, 1929
Cause of death given as "Fractured vertebrae with cord injury. Shock-multiple bruises."

Information DESIRED in order to complete certificate:

WHAT KIND OF ACCIDENT WAS THE PRIMARY CAUSE OF DEATH? IF AUTO WAS INVOLVED PLEASE NAME THE PLACE WHERE THE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Automobile accident - on highway near Culdesac Idaho

R.T.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67673

RECEIVED SEP 23 1929

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. [illegible]
Local Registrar's No.
(No. 1230 Eighty Lane)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary C. Jaggers

(a) Residence. No. 1230 Eighty Lane St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

44

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas Jaggers.

6. DATE OF BIRTH (month, day and year) July 25 1842

7. AGE	Years	Months	Days	If LESS than 1 day,
	87	—	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Philadelphia Penn.

PARENTS

10. NAME OF FATHER Thos. Hamilton.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Mary Hammond.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Mrs Fanny Sears
(Address) Lewiston Idaho.

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 15 — 29
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to Aug 15 — 1929
that I last saw her alive on Aug 15 — 1929
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach.
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Starvation.
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

8-16, 1929 (Signed) E. L. White, M. D.
(Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	8/17 1929
20. Undertaker	Address
Vassar Mortuary	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 23 1929

PLACE OF DEATH

County of Nez Perce

City of Lewiston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67674

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. Whites Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rose La Bolle.

(a) Residence. No. Deary Idaho. St. Deary Idaho. 181 B

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Thomas La Bolle.

6. DATE OF BIRTH (month, day and year) Jan 1, 1851

7. AGE Years 58 Months 8 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Dick Morris

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Jane Putley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Thos. La Bolle

(Address) Deary Idaho.

15. Filed Sept 8, 1929 Susan E Brune Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13, 1929, to Aug 16, 1929

that I last saw her alive on Aug 16, 1929

and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Measles with intestinal Complic colitis.

(duration) yrs. 2 mos. — ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cardinal symptoms

(Signed) E. L. White, M. D.

8-16, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Deary Idaho. Date of Burial 8/18 1929

20. Undertaker Vassar Mortuary Address Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67676

Local Registrar's No. 143A

PLACE OF DEATH

County of Nez Perce

City of Lewiston Ida

Registration District No. 9

Primary Registration District No.

(No. St Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucille Duffy

(a) Residence. No. 417 - 5th St St.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 28- 1903

7. AGE Years 26 Months 0 Days 15 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) General Office work

(c) Name of employer Nez Perce County

9. BIRTHPLACE (city or town) (State or country) Washington

PARENTS

10. NAME OF FATHER James L Duffy

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Elizabeth Conway

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant James L Duffy

(Address) Lewiston Ida

15. Filed Sept-8, 1929 Ewan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 13 19 29

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13, 1929, to Aug 18, 1929

that I last saw h[illegible] alive on Aug 13, 1929

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Criminal Abortion

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Probably Ruptured uterus (duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) E L Broadbeck, M. D.

Aug 15, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho — Date of Burial: Aug 16 1929

20. Undertaker: Vassar Mortuary — Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67677

Local Registrar's No.

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No.

(No. Bedford Hotel)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Byron

(a) Residence No. Bedford Hotel St. 74a

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs. John Byron

6. DATE OF BIRTH (month, day and year) Mar. 27 1857

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	72	4	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook. Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer) Manhattan Cafe

(c) Name of employer Prop.

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER John Byron

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Anna Loomis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y.

14. Informant Mrs. John Byron

(Address) Lewiston Idaho

15. Filed Sept 25, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1929, to ____, 19____

that I last saw h— alive on — 19____

and that death occurred, on the date stated above, at 6 to 9 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Chronic Inst. Nephritis.

(duration) 10 yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings.

(Signed) William Whitehead, M. D.

Aug. 12-1929 19 (Address) Lewiston - Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Seattle Wn	
20. Undertaker	Address
Bowen-Hawe Co	Lewiston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 23 1929

PLACE OF DEATH

County of Nezperce

City of Lewiston Orchards,

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 95

Primary Registration District No. 1009 2193 Local Registrar's No.

(No. Lewiston Orchards)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 27678

2. FULL NAME Vesta A. McDaniel

57

(a) Residence. No. Lewiston Orchards St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Femalr	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	53	0	21	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10. NAME OF FATHER Wm. Brady

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Ida S. Wood

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant [illegible] M. McDaniel

(Address) Lewiston Orchards

15. Filed July 8, 1929 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June, 18, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 18, 1929
that I last saw h[illegible] alive on June 18, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Coma (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Multiplex (duration) yrs. 6 mos. + ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) O. C. Carlson M. D.

6/19, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Normal Hill, Lewiston, Idaho.	6/20/29 19

20. Undertaker Brower - Mann Co., Address Lewiston, Idaho.

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67679

PLACE OF DEATH
County of Nez Perce
City of Spalding

Registration District No. 96 95
Primary Registration District No. 1009 2193
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME John Martin Walker
(a) Residence, No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1/7/1842

7. AGE Years 87 Months 5 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired (Old Soldier)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana.

PARENTS
10. NAME OF FATHER Alexander Walker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Mrs Flore Taylor
(Address) Lapwai, Idaho

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 24th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to June 22, 1929
that I last saw him alive on June 22, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Senility. No special on acute disease found, but gradual decline (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. M. Lyle, M. D.
6/25, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spalding Idaho
Date of Burial 6/26 1929

20. Undertaker Brown-Wann Co
Address Lewiston Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Johnson.

RECEIVED SEP 23 1929

DO NOT WRITE IN THIS SPACE

State File No. 67680

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Nez Perce,

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. St Joseph Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Marcus Brown. 41

(a) Residence. No. St. Clarkston, Washington.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nettie Brown.

6. DATE OF BIRTH (month, day and year) Nov. 23rd, 1877.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51.	7.	5.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada.

PARENTS

10. NAME OF FATHER ------- Brown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.

12. MAIDEN NAME OF MOTHER Canada.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs F M. Brown
(Address) Clarkston, Washington.

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1929, to June 28, 1929
that I last saw him alive on June 28, 1929
and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows: Septicemia a starting from abrasion on finger.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic blood.

(Signed) Paul W Johnson, M. D.

6/29/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clarkston, Washington.	6/30/29. 19
20. Undertaker	**Address**
Brower-Mann Company.	Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67681

PLACE OF DEATH

County of Nez Perce
City of Lewiston, Ida.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Grove

(a) Residence. No. Kooskia, Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or 15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Muriel B. Nicholson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant E. H. Nicholson
(Address) Grangeville, Ida.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 12. 1929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1929, to June 12, 1929
that I last saw h alive on , 19
and that death occurred on the date stated above, at m.
The CAUSE OF DEATH was as follows:

Stillborn
Placenta Previa
Premature

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [signature] M. D.
June 14, 1929 (Address) Lewiston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kooskia, Ida.	19

20. Undertaker	Address
Brower - Wann Co.,	Lewiston, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Cassow

RECEIVED SEP 23 1929

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67682

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. 0232 22nd, Street.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Just received to day Susan E Bruce

2. FULL NAME John E. Swisher.

(a) Residence. No. 0232 22nd, St. St. 101a

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillie Swisher.

6. DATE OF BIRTH (month, day and year): July 1st, 1870.

7. AGE: 58. Years | Months: 7. | Days: 1. | If LESS than 1 day, ___ hrs., or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Engineer.

(b) General nature of industry, business, or establishment in which employed (or employer): Water Department.

(c) Name of employer: City of Lewiston, Idaho.

9. BIRTHPLACE (city or town) (State or country): Charlston, Illinois.

PARENTS

10. NAME OF FATHER: Lockard Swisher.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois.

12. MAIDEN NAME OF MOTHER: Ellen Lemons.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois.

14. Informant: [signature]

(Address) Lewiston, Idaho.

15. Filed Sept 11, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 2nd, 1929. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jun 21st, 1929, to Feb 2nd, 1929, that I last saw him alive on Feb 2nd, 1929, and that death occurred, on the date stated above, at 1130 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Consolidation of lung

(Signed) D. C. Cassow, M. D.

2/4/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. | Date of Burial: 2/4/29. 19

20. Undertaker: Brower-Wann Company. | Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. [illegible] OCT 5 _ 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida

City of Malad

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26

Primary Registration District No. 2069

(No. ....., ... St.)

File No. 67683

Registered No. 25

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Henry Peck Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb. (Month) 7 (Day) 1890 (Year)

7. AGE: 39 Yrs. 7 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Doctor & Farmer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Malad Ida.

10. NAME OF FATHER: Charles H. Peck.

11. BIRTHPLACE OF FATHER (State or Country): Malad Ida.

12. MAIDEN NAME OF MOTHER: Annie M. Bywater

13. BIRTHPLACE OF MOTHER (State or Country): Brigham Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ✓ A B Peck

(Address) Malad Idaho

15. Filed 9-30 1929 J. M. Kerns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 10 (Day) 1929 (Year) 74a

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to Sept 10 1929 that I last saw h..... alive on ..... 19..., was dead when I arrived. and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows: Apoplexy? from symptoms given, was dead when I arrived.

..... (Duration) ..... Yrs. ..... mos. 3 hrs. ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Kerns M. D.

9-10 1929 (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Ida

DATE OF BURIAL: Sept. 14 1929

20. UNDERTAKER: J. Guy Benson

ADDRESS: Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25-M-1-19 RECEIVED OCT 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bayhill Co.

City of Bruneau

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 74

Primary Registration District No. 2151

(No. ..... St.)

File No. 67684

Registered No. 53

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Margaret Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Oct (Month) 24 (Day) 1928 (Year)

7. AGE: ..... Yrs. 11 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Bruneau Idaho.

10. NAME OF FATHER: Rosser Wilson

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Zetta Caudle.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rosser Wilson

(Address) Bruneau

15. Filed Oct 7 1929 W. J. Erkenbeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..., that I last saw h..... alive on ..... 19..., and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows: asphyxia, accidental foreign body in throat

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Erkenbeck Co Physician M. D.

Oct 1 1929 (Address) Grand View

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Bruneau

DATE OF BURIAL: Oct 2 1929.

20. UNDERTAKER: G. S. Zacher

ADDRESS: Mt Home.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 8 _ 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cruyhee

City of Bruneau

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 74

Primary Registration District No. 2151

(No. ..... , ... St.)

File No. 67685

Registered No. 52

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ola Eide

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: Oct (Month) 5 (Day) 1861 (Year)

7. AGE: 68 Yrs. 11 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Norway.

10. NAME OF FATHER: Eide

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carrie Eide

(Address) Bruneau.

15. Filed Oct. 7 1929

W. J. Erkenbach
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 31 Sept (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 - 1929, to 9-23- 1929, that I last saw him alive on 9-20- 1929, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... Yrs. 8 mos. ..... ds.

Contributory (Secondary) Influenza Febr. & March 1929

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) T. E. Evans M. D.

9-8-1929 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Bruneau.

DATE OF BURIAL: 9-27 1929

20. UNDERTAKER: G. S. Zacher.

ADDRESS: Mt Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67686

PLACE OF DEATH
County of Owyhee
City of Bruneau

Registration District No. 74
Primary Registration District No. 2151

Local Registrar's No. 50

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Unnamed Baby Groves

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 23rd, 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
				14 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bruneau, Idaho

PARENTS

10. NAME OF FATHER Jessie A. Groves

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Payette, Idaho

12. MAIDEN NAME OF MOTHER Ethel Dunning

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bruneau, Idaho

14. Informant Ethel Groves
(Address) Bruneau

15. Filed Oct. 1st, 1929 W J Eisenbeck Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 24th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 23rd, 1929, to , 19
that I last saw her alive on Sept. 23, 1929
and that death occurred, on the date stated above, at 9 a m
The CAUSE OF DEATH* was as follows:
Congenital malformation of heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Wm J Eisenbeck, M. D.
Oct. 1st, 1929 (Address) Grand View

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bruneau	Sept 24 1929
20. Undertaker: None	Address

RECEIVED OCT 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67687

PLACE OF DEATH
County of Owyhee
City of Bruneau

Registration District No. 74
Primary Registration District No. 2151
Local Registrar's No. 51

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ethel Dunning Groves

(a) Residence. No. ..... St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced
(or) WIFE of Jessie A. Groves

6. DATE OF BIRTH (month, day and year) July 28, 1889

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	2		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Bruneau, Idaho

PARENTS

10. NAME OF FATHER Dow Dunning

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Margaret Keith

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Jordan Valley, Idaho

14. Informant Jessie Groves
(Address) Bruneau

15. Filed Oct. 1st, 1929 W J Eckenbeck
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23rd, 1929, to Sept 27, 1929
that I last saw her alive on Sept. 27, 1929
and that death occurred, on the date stated above, at 8:15 A.m.
The CAUSE OF DEATH* was as follows:

Mitral Insuffiency

(duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Childbirth

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Wm. J Eckenbeck, M. D.
Oct. 1, 1929 (Address) Grand View

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bruneau	Sept. 29 1929

20. Undertaker C. G. Zacher
Address M. Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 24 1929

PLACE OF DEATH

County of Payette

City of Payette

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67688

Registration District No. 4

Primary Registration District No. 1008

Local Registrar's No. 26

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Guy Rea Hopkins 70

(a) Residence. No. 339 River Street St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 4 1910

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
19	3	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work school student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER James Speed Hopkins

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Levina R. Goodman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant A L Freehafer
(Address) Payette, Ida.

15. Filed Aug 9, 1929 J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17, 1929, to Aug 8, 1929 that I last saw him alive on Aug 8, 1929 and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Frontal sinusitis

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Encephalitis

(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 15 1929

Was there an autopsy? No

What test confirmed diagnosis? Spinal puncture

(Signed) Merrill R. Fox M. D.

Aug 9, 1929 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kuna Ida. Date of Burial Aug 11 1929

20. Undertaker Glenn C Landon Address Payette Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67689

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008.
Local Registrar's No. 27,

(No. 440)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Monica Ham.

(a) Residence. No. 1122 1st ave. N. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widow.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of David A. Ham.

6. DATE OF BIRTH (month, day and year) Sept 4 1850

7. AGE: Years 78. Months 9 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10. NAME OF FATHER Mr. Prentice.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown.
12. MAIDEN NAME OF MOTHER unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown.

14. Informant Fairy Danger.
(Address) Payette, Ida.

15. Filed Aug. 10 1929. J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19, 1928, to June 29, 1929
that I last saw her alive on June 29, 1929
and that death occurred, on the date stated above, at 1:00 p.m.
The CAUSE OF DEATH* was as follows:
Endocarditis. Mitral insufficiency

several (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical symptoms

(Signed) O. H. Avey, M. D.
7/10/, 1929 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette Ida.	July 6. 1929.
20. Undertaker	Address
Glenn C. Sanders.	Payette. Ida.

RECEIVED SEP 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67690

PLACE OF DEATH

County of Payette
City of Payette

CERTIFICATE OF DEATH

Registration District No. 4
Primary Registration District No. 1008
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 28

2. FULL NAME Pansy Martha Billings
(a) Residence. No. ..... St. Vale 129 Ore
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F
4 COLOR OR RACE H
5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of F Billings

6 DATE OF BIRTH (month, day and year) Sept 3 1894

7 AGE Years 34 Months 10 Days — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Las Animas Colo

PARENTS
10 NAME OF FATHER Frank Keough
11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known
12 MAIDEN NAME OF MOTHER Mary Lamb
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kans

14 Informant .....
(Address) F Billings Vale

15 Filed Aug 10, 1929. J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 29 (Day), 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1929, to July 29, 1929, that I last saw him alive on July 29, 1929, and that death occurred, on the date stated above, at 7.30p m.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial ephritis.

..... (duration) ..... yrs. 14 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of ---------
Was there an autopsy? Yes.
What test confirmed diagnosis? Autopsy Findings
(Signed) J C Woodward, M. D
7/31/29, 19.. (Address) Payette, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Baker Ore
Date of Burial Aug 1 1929

20 Undertaker J. H. Adair
Address Peterson Furn Co Payette Ida

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 24 1929

PLACE OF DEATH

County of Payette

City of Payette

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 4

Primary Registration District No. 1008

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67691

Local Registrar's No. 29

2. FULL NAME Caroline Mears

(a) Residence. No. Payette Ida St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

49

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

3a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Lewis M. Mears

6. DATE OF BIRTH (month, day and year) May 11-1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Mose Ropp

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant W. E. Mears

(Address) Payette Ida

15. Filed Aug 12, 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to Aug 8, 1929

that I last saw her alive on August 8, 1929

and that death occurred, on the date stated above, at 9:00 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of bladder

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage of bladder

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) O. A. Avey, M. D.

Aug 11, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette Ida	Aug 11 1929

20. Undertaker Glenn & Sanders Payette Ida

Address

RECEIVED SEP 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67693

PLACE OF DEATH

County of Payette
City of Payette

CERTIFICATE OF DEATH

Registration District No. 4
Primary Registration District No. 1008
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 31

2. FULL NAME Nancy J. Jenks

(a) Residence. No. ..... St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F
4 COLOR OR RACE W
5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Albert E Jenks

6 DATE OF BIRTH (month, day and year) July 6

7 AGE Years 73 Months 1 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind

PARENTS
10 NAME OF FATHER John Pyles
11 BIRTHPLACE OF FATHER (city or town) (State or country) Vir
12 MAIDEN NAME OF MOTHER Mary F. Miller
13 BIRTHPLACE OF MOTHER (city or town) (State or country) ✓ ✓

14 Informant R R Hanson
(Address) Payette Ida

15 Filed Aug 18, 1929 J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 17 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov., 1928, to Aug 17, 1929, that I last saw her alive on Aug 17, 1929, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:
Cardiovascular - hypertensive disease
..... (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Iowa
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Merrill R. Fox, M. D.
Aug 18, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Scranton Iowa
Date of ~~Burial~~ Shipp 29

20 Undertaker G H Adams
Address Peterson Furn Co Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67694

PLACE OF DEATH
County of Payette
City of Payette.

Registration District No. 4
Primary Registration District No. 1008.
Local Registrar's No. 32.
(No. 44)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William I Hale.

(a) Residence. No. 206 7th South St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ellen Hale

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	11		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Alabama.

PARENTS

10. NAME OF FATHER unknown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown.

12. MAIDEN NAME OF MOTHER Rhoda Powell.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown.

14. Informant Calvin Hale
(Address)

15. Filed Aug 27, 1929. J B Woodward
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 25, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22, 1929, to June 12, 1929
that I last saw h alive on June 12, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH was as follows:
Cancer of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Symptoms
(Signed) J C Woodward M. D.
Aug 27, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette Ida.	Aug 27 1929
20. Undertaker	Address
Glenn C Sanders	Payette Ida.

TION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67695

PLACE OF DEATH

County of Payette
City of ~~Burt Plymouth~~ New Plymouth

Registration District No. 5
Primary Registration District No. 1009
(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 3

2. FULL NAME Fridrick Riebel

(a) Residence. No. St. 74a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M
4 COLOR OR RACE: W.
5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) March 6 1841

7 AGE: 88 Years, 5 Months, 14 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Minister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS
10 NAME OF FATHER: Riebel
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Clayton Judy
(Address) New Plymouth Ida

15 Filed Aug 21, 1929 Wm T. Drysdale Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug (Month) 21 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from viewed the remains to after death, 19
that I last saw him alive on Aug 20, 1929,
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Probably apoplexy -
Patient was found dead in bed after having retired in good health the night before
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility -
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Wm T. Drysdale, M. D.
Aug 21, 1929 (Address) New Plymouth

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Columbus Ohio
Date of Burial: Aug 22 1929

20. Undertaker: J. H. Adams
Address: Peterson Furn Co Payette Ida

RECEIVED SEP 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67696

PLACE OF DEATH
County of Payette
City of Fruitland
Registration District No. 51
Primary Registration District No. 7130
(No.)
Local Registrar's No. 7

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Charles T Baller

(a) Residence. No. 162 St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug. 11 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10 NAME OF FATHER L S Baller
11 BIRTHPLACE OF FATHER (city or town) (State or country) Kans
12 MAIDEN NAME OF MOTHER Snowie McCreary
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Colo

14 Informant L. S. Baller
(Address) Fruitland Idaho

15 Filed Aug 16, 1929 Mrs Wm J. Dryden Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 16 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1929, to Aug 16, 1929, that I last saw him alive on Aug 16, 1929, and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical evidence

(Signed) Wm J. Dryden, M. D.

8-16, 1929 (Address) Mrn Payette

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Payette Ida	Aug 17 1929
20. Undertaker D. H. Adair	Address
Peterson Mrn Co	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67697

PLACE OF DEATH

County of Power
City of Rockland
Registration District No. 25
Primary Registration District No. 2072
(No. a)
Local Registrar's No. 25

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Glen Kelley

(a) Residence. No. 1000 St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 8-31-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			12	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) American Falls Idaho

PARENTS

10 NAME OF FATHER Bertie Carlyle Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calls Fort Utah

12 MAIDEN NAME OF MOTHER Lois Lovina Rudph

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rockland Idaho

14 Informant X Bill C Kelley
(Address) Rockland, Ida

15 Filed 9-27, 1929 Genevieve Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 11th 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 9th, 1929, to Sept 11, 1929, that I last saw h- alive on Sept 11, 1929, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) V H Fagan, M. D.
9-19, 1929 (Address) Rockland Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67698

PLACE OF DEATH

County of Power
City of American Falls
Registration District No. 25
Primary Registration District No. 2079
(No. .....)
Local Registrar's No. 24

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Christina Mary Lawson

(a) Residence. No. 160 St.
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem-		

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept 19 - 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) .....

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Della Vern Blackburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Nebr.

14 Informant D Earl Lawson
(Address) .....

15 Filed 9-21, 1929 Genevieve Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 21 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 9-19, 1929, to 9-21, 1929, that I last saw her alive on 9-21-, 1929, and that death occurred, on the date stated above, at 7 20 a.m.

The CAUSE OF DEATH* was as follows:
Tetanus Neonatorum
..... (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) W H Logan, M. D.
9-21, 1929 (Address) American Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Rockland	9-21 1929
20. Undertaker	Address
A W Davis	Am Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67700

PLACE OF DEATH
County of Sho Shone
City of Hippaheak Mine (Hypotheek)

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 43

2. FULL NAME Alma Susine Devereaux

(a) Residence. No. ..... St. 129
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 14, 1915

7. AGE Years: 14 Months: 7 Days: 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kingston, Ida.

PARENTS

10. NAME OF FATHER: Alvin Devereaux
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Rush Ill.
12. MAIDEN NAME OF MOTHER: Hettie Jane Tucker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tyler Wash

14. Informant: Mrs. E. S. Tucker
(Address) Kingston Ida.

15. Filed Sept. 7, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1929, to Sept 1, 1929
that I last saw her alive on Aug 15, 1929
and that death occurred, on the date stated above, at 11.45 A m.
The CAUSE OF DEATH* was as follows:
Nephritis and Mitral trouble,
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. R. Mason, M. D.
Sept 6, 1929 (Address) Kellogg, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kingston, Ida. Date of Burial: Sept 3, 1929

20. Undertaker: M. C. Thornhill Address: Kellogg

RE[illegible] ED OCT 7 1929

STATE OF IDA
DEPARTM[illegible] OF PUBLIC WELFAI
BUREA[illegible] VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67701

PLACE OF DEATH
County of Shoshone
City of Kellogg
Registration District No. 123
Primary Registration District No. 2207
Local Registrar's No. 42
(No. [illegible])
(If death occurred in a hospital or institution, give its name instead of street and number.)

182

2. FULL NAME Jacob E Swanberg

(a) Residence. No. [illegible] St. [illegible]
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Teamster
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Crino Construction co

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant C. E. Nicson
(Address) Kennewick Wash

15. Filed Sept. 7, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible], 19[illegible], to [illegible], 19[illegible]
that I last saw h[illegible] alive on [illegible], 19[illegible]
and that death occurred, on the date stated above, at 5:45 a.m.
The CAUSE OF DEATH* was as follows:
Drowned in Coeur d'Alene Lake Robert near Cedar Island While riding horses about (duration) [illegible] yrs. [illegible] mos. [illegible] ds.
CONTRIBUTORY (Secondary) None
(duration) [illegible] yrs. [illegible] mos. [illegible] ds.

18. Where was disease contracted if not at place of death? [illegible]
Did an operation precede death? No Date of [illegible]
Was there an autopsy? [illegible]
What test confirmed diagnosis? [illegible]

(Signed) [illegible], M. D.
Sept 7, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kennewick Wash	Sept 8 1929

20. Undertaker R. L. Stout — Address Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 8 1929

PLACE OF DEATH

County of Teton

City of Tetonia.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 77

Primary Registration District No. 2176

DO NOT WRITE IN THIS SPACE

State File No. 67702

Local Registrar's No. 9

(No. 129)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jane Eleanor Hullmer.

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F. M.	W.	Widowed.

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Oscar Hullmer.

6. DATE OF BIRTH (month, day and year) March 6-1848

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	6	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England.

PARENTS

10. NAME OF FATHER John Griffiths

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.

12. MAIDEN NAME OF MOTHER Eleanor Griffiths

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Oscar Hullmer.

(Address) Tetonia, Ida.

15. Filed 9-16-, 1929. Martha Marker Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~July~~ 9 (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 20, 1929, to Sept 16, 1929, that I last saw h~~er~~ alive on Sept 1, 1929, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) Unknown yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. J. Parkinson, M. D.

, 19 (Address) Driggs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Logan Utah	Sept 20 1929

20. Undertaker Address

C. E. Edwards Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 25M. 1-19.

RECEIVED OCT 9 - 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 67703

Local Registrar's No.

1. PLACE OF DEATH
County of Valley
City of Roseberry
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Winsel McDougal Jr. 1610

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Premature Baby 6½ mo.
6. DATE OF BIRTH: 9 (Month) 17 (Day) 1929 (Year)
7. AGE: ... Yrs. X Mos. ... ds.
IF LESS than 1 day, how many 2½ hrs. or ... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Roseberry, Idaho.
10. NAME OF Father: Winsel McDougal
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Opal Pottenger
13. BIRTHPLACE OF MOTHER (State or Country): Idaho.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)
15. Filed Sep 18 1929 Stella Cain Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) – 17 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 9-17-29 1929 to 9-17 1929 that I last saw ~~him~~ alive on 9-17 1929. and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:
Premature baby
Six and one half months
(Duration) X yrs. X mos. X ds.
Contributory (Secondary) none
(Duration) X yrs. X mos. X ds.
(Signed) Dr. U. L. Cerff M. D.
1929 (Address) McCall Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19...

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67704

PLACE OF DEATH

County of Valley
City of McCall

Registration District No.
Primary Registration District No.
(No. McCall, Ida)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 69

2. FULL NAME Charles Linious Joy

(a) Residence. No. 1102 Hays. St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Grace L. Joy.

6 DATE OF BIRTH (month, day and year) Aug 30, 1858

7 AGE: Years 71 | Months 0 | Days 0 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Druggist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Illion New York.

PARENTS
10 NAME OF FATHER: Henry Joy
11 BIRTHPLACE OF FATHER (city or town) (State or country): Illion New York
12 MAIDEN NAME OF MOTHER: Mary Lyon
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Illion New York

14 Informant: Rily H. Joy
(Address) 1102 - Hays.

15 Filed 9/3, 1929 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug (Month) 30 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I ~~attended~~ examined today of deceased ~~from~~ 8/30, 1929, to ~~—~~, 19..., that ~~I last saw h~~ ~~alive on~~ ~~—~~, 19..., and that death occurred, on the date stated above, at about 1:30 m.

The CAUSE OF DEATH* was as follows: Probable shock & heart strain in fall from horse; fall induced by stroke or heart attack.
(duration) instantaneous yrs. mos. ds.

CONTRIBUTORY (Secondary): Heart disease
(duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? Boise, Ida.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Superficial Exam.

(Signed) Roy S Humphrey, M. D.
8/30, 1929 (Address) McCall Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Sept 1 1929

20. Undertaker: Summers & Krebs
Address: Boise Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 14 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 67705

Registered No. [illegible]

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

County of Adams

City of Indian Valley (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Agnes Duncan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 15 (Day) 1847 (Year)

7. AGE: 82 Yrs. 5 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Joe McMahon

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse E Duncan

(Address) Lyle Oregon

15. Filed 10-11-29 191.... [signature] Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Heart Disease (?)

No physician called

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

19..... (Address) Cambridge, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon City Ore — DATE OF BURIAL ..... 191....

20. UNDERTAKER: J A Anderson — ADDRESS Cambridge

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67706

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 75
(No. U. S. Veterans Bureau, Boise, Idaho.
(If death occurred in a hospital or institution, give its name instead of street and number.)

133

2. FULL NAME Hartvig M. Simonson

(a) Residence. No. New Scott Hotel St. Portland, Oregon
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 9 mos. 17 ds. How long in U. S., if of foreign birth? XX yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) February 16, 1889

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	7	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) XX
(c) Name of employer XX

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER XX

11. BIRTHPLACE OF FATHER (city or town) (State or Country) XX

12. MAIDEN NAME OF MOTHER XX

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) XX

14. Informant L. Kromer
(Address) U. S. Veterans Bureau, Boise, Idaho.

15. Filed 9-27, 1929 W. N. Rhodes Registrar
K.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 7, 1928, to September 24, 1929
that I last saw him alive on September 24, 1929
and that death occurred, on the date stated above, at 9:45 P.M.
The CAUSE OF DEATH* was as follows:
Pyelonephritis
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Cystitis, chronic.
(duration) 6 yrs. 9 mos. ds.

18. Where was disease contracted if not at place of death? XX
Did an operation precede death? Yes Date of (11-2-27, 6-8-28, 6-27-29, 8-7-29)
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Laboratory

(Signed) F. C. SMITH U.S.Vet.Bureau, M. D.
Sept. 26, 1929. (Address) Boise, Idaho.
Regional Medical Officer.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Portland, Oregon.	Shipped 9/27/29 19
20. Undertaker	Address
Wm. McBratney	Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1929

PLACE OF DEATH

County of Ida

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67707

Local Registrar's No. 73

135

2. FULL NAME W. G. Pennington

(a) Residence. No. County Hospital St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years '74 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Not Known

PARENTS

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (city or town) (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: W. McBratney
(Address) Boise, Idaho

15. Filed Sept. 14, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) — 9 (Day) — 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 1, 1927, to Sep 9, 1929 that I last saw him alive on Sep 8, 1929 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Prostatic Hypertrophy.

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Pyelitis

(duration) ..... yrs. 6 mos. 9 ds.

18. Where was disease contracted if not at place of death? Ada County

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) J. N. Brattan M. D.

9-11-29, 19.... (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Franklin, Pa. | Date of Burial: — 19

20. Undertaker: W. McBratney | Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67708

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 71
(No. Ada County Hospital.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Bailey.

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of ----------
(or) WIFE of

6. DATE OF BIRTH (month, day and year) December 1st 1865

7. AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	63	8	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Albama Co. N. Y.
(State or country)

PARENTS

10. NAME OF FATHER Freeman Bailey.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hartford, Conn.
12. MAIDEN NAME OF MOTHER Eliza Jane Huff.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York.

14. Informant Mrs. Anna M. Anderson.
(Address) Boise, Idaho.

15. Filed 9-3, 1929 W. A. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 30th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to Aug 30, 1929
that I last saw h live on Aug 29, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Progressive Muscular Atrophy
(duration) 1 yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. 1 mos. 30 ds.

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) T. H. Brayton M. D.
8/31/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 9/2/29, 19

20. Undertaker: Wm. McBratney. — Address: Boise, Idaho.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67709

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 79
(No. 164)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Norbois
(a) Residence. No. 1/4 Mile No Collister Station St.
(Usual place of abode)
Length of residence in city or town where death occurred. 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):
5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lena Norbois
6. DATE OF BIRTH (month, day and year) Sept 9, 1851
7. AGE: Years 77 | Months 11 | Days 21 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): England

PARENTS
10. NAME OF FATHER: Jesse Norbois
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Mary Ann Woldak
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Eddie J. Norbois
(Address) Boise Idaho.
15. Filed 9-3, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 30 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 8/29/29, 19..., to 8/30/29, 19...
that I last saw him alive on August 29, 1929
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Senility
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Dysentery
(duration) yrs. mos. 6 ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Harold W Stone, M. D.
Aug 30, 1929 (Address) 317 Eastman Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dry Creek Cemetery	Aug. 31 1929
20. Undertaker	Address
Summers & Twelves	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 4 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. St Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 6771 0

Local Registrar's No. 238

740

2. FULL NAME Clayton Tiffen Moulton

(a) Residence. No. Emmett St. Idaho

(Usual place of abode)

Length of residence in city or town where death occurred. — yrs. — mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
~~(wife) of~~ HUSBAND of Sarah Marie Moulton

6. DATE OF BIRTH (month, day and year) May 25, 1853

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	3	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gentry County, Mo.

PARENTS

10. NAME OF FATHER Pierpont H. B. Moulton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) St. Lawrence County New York

12. MAIDEN NAME OF MOTHER Nancy Jane Martin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Gentry County, Missouri

14. Informant Mrs L. T. Moulton

(Address) Emmett Idaho

15. Filed 9-17, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 14, 1929, that I last saw h~~im~~ alive on Sept 14, 1929, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred Collett M. D.

Sept 14, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	9/17 1929

20. Undertaker C. D. Buckman — Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67711

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospt.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 237

2. FULL NAME A. Resnick

(a) Residence. No. [redacted] Boise, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 45			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheep Shearer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Not Known
(State or country)

PARENTS

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant W. McBratney
(Address) Boise, Idaho.

15. Filed 9-16 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) — 11 (Day) — 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug 18, 1929, to Sept 11, 1929
that I last saw him alive on Sept 6, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Pernicious Anaemia
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. 22 ds.

18. Where was disease contracted if not at place of death? Ada County
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Blood Exam
(Signed) J. H. Brashear M. D.
Sept 12, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	9-16-1929
20. Undertaker W. McBratney	Address Boise Idaho

Boise

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67712

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 3
Primary Registration District No. 1904
(No. St Lukes Hospital)
Local Registrar's No. 231
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eric M Dahlberg
(a) Residence. No. 1/2 mile South of Eistick 133
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Married

5a. If married, widowed or divorced
HUSBAND of (or) WIFE of: Johanna Dahlberg

6. DATE OF BIRTH (month, day and year): Nov. 14 - 1851

7. AGE: Years 77 | Months 9 | Days 22 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Matis Gynderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Ellen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Mrs. Eric M Dahlberg
(Address) Eistick Idaho

15. Filed 9-13, 1929 W. H. Rhodes Registrar
P.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 10th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20th, 1929, to Sept 10th, 1929, that I last saw h. alive on Sept 10th, 1929, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:
Hemorrhage following removal of Prostate gland.
(duration) yrs. mos. ds.
CONTRIBUTORY. (Secondary) Bladder trouble for years.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Lotus Brink M. D.
Sept 13, 1929 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Sept 14 1929
20. Undertaker: Summers & Krebs — Address: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Parker

DO NOT WRITE IN THIS SPACE

State File No. 67713

Local Registrar's No. 235

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 3

Primary Registration District No. 1004

(No. 516 N. 15 Street)

(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Emma Lockey Stone.

(a) Residence. No. 516 N. 15 Street St.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 18-1844

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	9	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10. NAME OF FATHER John Hagadorn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Lockey Gennung

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Mrs. Mabel G. Stone

(Address) 516 N 15 St Boise Idaho

15. Filed 9-12, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1929, to Sept 11, 1929, that I last saw h[illegible] alive on Sept 10, 1929, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Senility, heart block

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken Hip - fell in house getting up from chair. (duration) yrs. mos. 17 ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) O H Parker, M. D.

Sept 12, 1929 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pioneer Cemetery	Sept 13 1929

20. Undertaker Summers & Krebs Address Boise Idaho

RECEIVED FEB 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67713

Dr. O.H. Parker
Boise

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Emma Lockey Stone who died Sept. 11, 1929
Cause of death given as "Inanition, senility, shock." "Broken hip."

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO WAS INVOLVED PLEASE NAME THE PLACE WHERE THE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

She fell in the house getting up from chair... and broke her hip.

O H Parker. MD

SEP 25 1978

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Boise

DO NOT WRITE IN THIS SPACE
State File No. 67714

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 334

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leonard Logan

(a) Residence. No. 1208 N. 12 St.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

98 B

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Logan,

6. DATE OF BIRTH (month, day and year) July 23 1862

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	1	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Vault Attendant

(b) General nature of industry, business, or establishment in which employed (or employer) Boise City Nat Bank

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Thomas E. Logan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wis

12. MAIDEN NAME OF MOTHER Caroline Leonard

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wis.

14. Informant Mrs. Leonard Logan

(Address) 1208 N. 12 st Boise Idaho

15. Filed 9-12, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1929, to Sept 11, 1929

that I last saw h[illegible] alive on Sept 11, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Recurrent Inflammatory Rheumatism (duration) 50 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical findings

(Signed) Agnes Burge M. D.

Sept 11, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pioneer Cemetery	Sept 13 1929
20. Undertaker	Address
Summer & Krebs	Boise Idaho

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67716

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 232

(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ira Marcellus Rutledge 92 2

(a) Residence. No. 6 miles West of Boise
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Married

5a. If married, widowed or divorced
HUSBAND of (or) WIFE of: Carrie L. Rutledge

6. DATE OF BIRTH (month, day and year): Oct 7 1863

7. AGE

Years	Months	Days	If LESS than 1 day,
65	11	1	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: Mathew J Rutledge
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Martha E Wheeler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: Mrs Ira M Rutledge
(Address) R.R. 3. Boise Idaho

15. Filed 9-9, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 8, 1929, that I last saw h[illegible] alive on Sept 7, 1929, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:
Coronary Thrombosis of a branch of artery to left ventricle -
(duration) yrs. 7 mos. da.
CONTRIBUTORY (Secondary) Pulmonary Oedema
(duration) yrs. mos. 1 da.

18. Where was disease contracted if not at place of death? Ada County
Did an operation precede death? No Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) J. M. Braffard M.D.
Sept 9, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Sept 11 - 29
20. Undertaker: Summers & Trubs. — Address: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67717

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 23

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

101B

2. FULL NAME Mrs Anna C. Goldtrap

(a) Residence. No. 1216 Franklin St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel K. Goldtrap died

6. DATE OF BIRTH (month, day and year): Jan 1st 1840

7. AGE: 5 Years: 89 Months: 8 Days: 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mt Carmel Indiana

PARENTS

10. NAME OF FATHER: Hartus Cunningham

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Hartus E. Cunningham (Address) 710 North 20th Boise Id

15. Filed 9-9, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Sep 1, 1929 that I last saw her alive on Aug 31, 1929 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

~~Senility~~ Pneumonia Hypostatic (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Fred A. Pettengill, M. D.

9/5, 1929 (Address) Boise Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pioneer Cemetery Date of Burial: 9/5 1929

20. Undertaker: Schreiber & McCann Address: Boise, Ia

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67718

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 1123 State Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 230

2. FULL NAME Mathilda Patricia Witchey 129

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 7-1914

7. AGE Years 15 Months 5 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cascade, Ida

PARENTS

10. NAME OF FATHER Abner C. Witchey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Neb.
12. MAIDEN NAME OF MOTHER Ida Schneider
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Neb

14. Informant Abner C. Witchey
(Address) Boise

15. Filed 9-7, 1929 W. H. Rhodes Registrar
Pittenger

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22, 1929, to Sept 4, 1929
that I last saw her alive on Sept 4, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:

Myocardial Degeneration following acute Articular Rheumatism
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis
..... (duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms
(Signed) Fred A. Pittenger, M. D.
9, 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery — Date of Burial 9/6 1929

20. Undertaker Schneider & McCann — Address Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67719

Registration District No. 3
Primary Registration District No. 1004
Local Registrar's No. 229

PLACE OF DEATH

County of Ada
City of Boise
(No.) St Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Tilly Riddle

(a) Residence. No. 620 S 16 St. St. 41
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 5, 1928

7. AGE — Years: — Months: 1 — Days: 0 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Boise Idaho

PARENTS

10. NAME OF FATHER: Andrew James Riddle
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Cleora Frisk
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Colorado

14. Informant: Andrew J Riddle
(Address) 620 S 16 St. Boise Idaho

15. Filed 9-6, 1929 W. F. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ Sept 2, 1929, to Sept 5, 1929
that I last saw her alive on Sept 5 1929
and that death occurred, on the date stated above, at 8:35 A. m.
The CAUSE OF DEATH* was as follows:

Septicemia

(duration) — yrs. — mos. 5 ds.
CONTRIBUTORY (Secondary): Anemia of new-born
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of ✓
Was there an autopsy? Yes.
What test confirmed diagnosis? Autopsy.

(Signed) Harmon Germaine M. D.
9-6, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Sept 6 1929
20. Undertaker	Address
Summers & Krebs	Boise Idaho

Stone

RECEIVED SEP 2 1929
RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67720

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 228
(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harold H. Martin

(a) Residence. No. 23rd & Pennsylvania Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 21, 1909

7. AGE	Years	Months	Days	If LESS than 1 day,
	19	11	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Ida

PARENTS

10. NAME OF FATHER Frank R. Martin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jackson Michigan
12. MAIDEN NAME OF MOTHER Isabel Neil
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vancouver Washington

14. Informant Frank R. Martin
(Address) 23rd & Pennsylvania

15. Filed 9/5, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1926, to August 31, 1929
that I last saw him alive on August 31, 1929
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Cerebral Tumor, undetermined nature & location;
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Internal Hydrocephalus
(duration) 3 yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Harold W. Love, M. D.
..., 19... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Sept 2 1929
20. Undertaker	Address
Summers & Hebb	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Lambaugh

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67721

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 227

2. FULL NAME Richard Fisher Hopewell

(a) Residence. No. Gordon Ave Cor Franklin St.
(Usual place of abode)
Length of residence in city or town where death occurred. 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 11, 1912

7. AGE	Years	Months	Days	If LESS than 1 day,
	17	4	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho.

PARENTS

10. NAME OF FATHER Charles E. Hopewell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denver Missouri
12. MAIDEN NAME OF MOTHER Minnie Fischer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Allentown Pennsylvania

14. Informant C. E. Hopewell
(Address) Gordon Ave Boise Ida

15. Filed 9-4, 1929 A. V. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-28-, 1929, to 8-29-29, 19
that I last saw h— alive on 8-29-29, 19
and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic (Staphococcic) Pneumonia (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes What test confirmed diagnosis? Heart Blood culture

(Signed) Ernest E. Tuthill, M. D.
9-4-29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Sept 1 1929
20. Undertaker	Address
Summers & Krebs	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1929

PLACE OF DEATH

County of Ada.

City of Boise.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67722

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 226

(No. 10th and Borah street.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

170 R

2. FULL NAME F. E. Young.

(a) Residence. No. 10th and Borah street. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About 70 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown.

PARENTS

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (city or town) (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Pearl Allen.

(Address) Boise, Idaho.

15. Filed 8-3, 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: About Aug - 24, 1929. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That ~~I attended deceased from ... 19 ... to ... 19 ... that I last saw ... alive on ... 19 ... and that~~ death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows: Suicide. Shot himself in head with 38 caliber revolver.

Found Dead (duration) yrs. mos. ds. Aug 28, 1929.

CONTRIBUTORY (Secondary)

No Inquest was held. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm McBratney - Coroner, M. D.

8/30/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: 8/30/29 19

20. Undertaker: Wm. McBratney | Address: Boise, Ida.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67723

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. St. Lukes)

Local Registrar's No. 225

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ethelyn M Pennington

(a) Residence. No. ..... St. .....

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 28 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work xx

(b) General nature of industry, business, or establishment in which employed (or employer) xx

(c) Name of employer xx

9. BIRTHPLACE (city or town) (State or country) Boise Idaho

PARENTS

10. NAME OF FATHER C-L-Pennington

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bear Creek Missouri

12. MAIDEN NAME OF MOTHER Emma J Strom

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canebridge Minnesota

14. Informant C-L-Pennington

(Address) Meridian Idaho R 3

15. Filed 9-3, 1929 W. H. Rhodes Registrar

R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1929, to Aug 31, 1929

that I last saw her alive on Aug 31, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary atelectasis
& Hyper Pyrexia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Local

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. M. Brayton, M. D.

Aug 31, 1929 (Address) Boise Idaho,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Cemetary	1929

20. Undertaker W. S. [illegible] Address Meridian Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67724

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 252

(No. St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fanny Irvin

(a) Residence. No. 1017 East Jefferson St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

14a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Jany 15. ~~190~~ 1854

7. AGE 75 Years | Months 8 | Days 11 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Librarian
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Supreme Court of Idaho

9. BIRTHPLACE (city or town) (State or country) Buffalo, N.Y.

PARENTS
10. NAME OF FATHER (Col.) Charles H. Irvin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Yorkshire, English
12. MAIDEN NAME OF MOTHER Isabella A. Harraden
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) London, Eng.

14. Informant (Address) Marie J. D. Irvin, Boise

15. Filed 9-30, 1929 W. H. Rhodes Registrar
R.S. Dr Coats

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1927, to Sept 26, 1929
that I last saw her alive on Sept 20, 1929
and that death occurred, on the date stated above, at 8.30 A m.
The CAUSE OF DEATH* was as follows:
Apoplexy
Chronic interstitial nephritis
Coma
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) A. J. Coats, M. D.
, 19 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pioneer Cemetery | Date of Burial: 9/27 1929
20. Undertaker: Schreiber & McCann | Address: Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 4 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. 122)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67725

Local Registrar's No. 251

2. FULL NAME Emma Bevenue

(a) Residence. No. East of Broadway Park Blvd.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of John Bevenue

6. DATE OF BIRTH (month, day and year) 1860

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	69			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Mardar Chamberlain

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill

12. MAIDEN NAME OF MOTHER Saphia Rickar

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Iren Chamberlain

(Address) Boise Idaho

15. Filed 9-30, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1929, to Sept 15, 1929

that I last saw h.. alive on Sept 15 1929

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Sclerosis of Liver

? (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute endocarditis

? (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) O H Taber, M. D.

Sept 24, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Johns Cemetery	9/30 1929

20. Undertaker Schreiber & McCann Address Boise Ida

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67726

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 250

49

2. FULL NAME Francisco Unamuno
(a) Residence. No. 617 Grove St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Angela Unamuno

6. DATE OF BIRTH (month, day and year): April 3, 1878

7. AGE: Years 51, Months 5, Days 21. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Hotel
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Spain

PARENTS

10. NAME OF FATHER: Valentin Unamuno
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Spain
12. MAIDEN NAME OF MOTHER: Gregoria Gueisuraga
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Spain

14. Informant: Martina Bicandi
(Address) 617 Grove

15. Filed 9-30, 1929 W. H. Rhodes
R. S. Registrar
Pittenger

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) - 25 (Day) - 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/25, 1929, to 9/25, 1929
that I last saw her alive on 9/25, 1929
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Coronary Thrombosis
(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms
(Signed) Fred A. Pittenger, M. D.
9/27, 1929 (Address) Boise Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. John's Cemetery — Date of Burial: 9/28 1929
20. Undertaker: Schneeber & McCann — Address: Boise Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67727

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 249
(No. 1610) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clifton Aaron Smith

(a) Residence. No. 415 North 4th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept. 23 - 1928

7. AGE — Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise, Ida

PARENTS

10. NAME OF FATHER: Emery Aaron Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Red Oak Iowa

12. MAIDEN NAME OF MOTHER: Eva Dysardin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Red Oak, Iowa

14. Informant: Mrs Lornett Short
(Address): Nash

15. Filed 9-30, 1929 W. H. Rhodes Registrar
R. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 24 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 23, 1929, to Sep 24, 1929
that I last saw him alive on Sep 24, 1929
and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:
Premature Birth -
6 1/2 months foetus -
Convulsions
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) John Booth M. D.
Sep 27, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. John's Cemetery	9/27 1929
20. Undertaker	Address
Schneider & McBaine	Boise

Dr. John Booth

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67728

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1604
Local Registrar's No. 248
(No. St Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Elizabeth Boatright.

(a) Residence. No. 407 Main street St.
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 5 1867

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	1	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS
10. NAME OF FATHER Merritt C Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Eliz Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minnesota

14. Informant Mrs Lothie Andrews
(Address) 407 Main St Boise Idaho

15. Filed 9-28, 1929 W. H. Rhodes R. S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1929, to Sept 27 1929, that I last saw h alive on Sept 26 1929, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows
Cerebral Hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) High Blood Pressure + Valvular heart lesion
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Lewis Boyd M. D.
Sept 27, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Sept 29 1929
20. Undertaker	Address
Summers & Keeler	Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Pittenger

DO NOT WRITE IN THIS SPACE
State File No. 67729

PLACE OF DEATH

County of Ida

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 247

(No. St Alphonsus Hospital.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Verness Ronald Field. 50

(a) Residence. No. 2422 Madison St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March. 15-1903

7. AGE Years: ~~18~~ 26 Months: 6 Days: 9 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Ida

PARENTS

10. NAME OF FATHER: G. W. Field

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ogden Utah

12. MAIDEN NAME OF MOTHER: Ida Clifford

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ogden Utah

14. Informant: R. W. Field

(Address) 2422 Madison St Boise Idaho

15. Filed 9-28, 1929 W. H. Rhodes Registrar

R. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug-8-, 1929, to 9/26, 1929

that I last saw him alive on 9/26, 1929

and that death occurred, on the date stated above, at 6 45 p.m.

The CAUSE OF DEATH* was as follows:

Brain Tumor (Cyst)

Fell striking back of head (duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) rupturing Cyst.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Fred A. Pittenger M.D.

9/27, 1929 (Address) Boise Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa Idaho

Date of Burial: Sept 30 1929

20. Undertaker: Summers & Krebs

Address: Boise Idaho

Dr. Bradley

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67730

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 245

(No. 2207 N. 13th Street.
(If death occurred in a hospital or institution, give its name instead of street and number.)

118 B

2. FULL NAME Chris G. Longeteig.

(a) Residence. No. 2207 N. 13th St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Harriett Longeteig.

6. DATE OF BIRTH (month, day and year): Dec. 10th 1845

7. AGE: 83 Years, 9 Months, 16 Days. If LESS than 1 day, ---------- hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming and General

(b) General nature of industry, business, or establishment in which employed (or employer): Mercantile.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bergen, Norway.

PARENTS

10. NAME OF FATHER: George Bailey.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Don't Know.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway.

14. Informant: Louis Longeteig.

(Address) Boise, Idaho.

15. Filed 9-28, 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 26th 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1927, 19, to Sept 26, 1929 that I last saw him alive on Sept 26, 1929 and that death occurred, on the date stated above, at 12:50 A.M.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Chronic Constipation

(duration) 15 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Alfred Budge Jr., M. D.

9/26/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 9/27/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67731

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 244

(No. 1716 N. 7th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Mrs. Maria L. Pitkin.

(a) Residence. No. 1716 N. 7th St.
(Usual place of abode)
Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Milo J. Pitkin.

6. DATE OF BIRTH (month, day and year) March 7th 1843.

7. AGE Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
86	6	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Glenns Falls, N. Y.
(State or country)

PARENTS

10. NAME OF FATHER Joshua H. Rogers.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Jane Lyttle.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y.

14. Informant Rev. E. C. Pounds.

(Address) Boise, Idaho.

15. Filed 9-23 19 29 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 23rd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 19 29, to Sept 22, 19 29
that I last saw h alive on Aug 1, 19 29
and that death occurred, on the date stated above, at 10 A.M m.

The CAUSE OF DEATH* was as follows:

Senility, Nephritis
Bowel Obstruction
Sarcoma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension, Constipation
Bowel Obs (duration) 2 yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) C H Parker, M. D.

9/23/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	9/24/29 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67732

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 243

2. FULL NAME Elizabeth Jane McGinnes 74a
(a) Residence. No. Little Valley, near Bruneau
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wht
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: W T McGinnes

6. DATE OF BIRTH (month, day and year): Aug 22, 1870

7. AGE: Years 59 | Months — | Days 28 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Walla Walla Wash.

PARENTS
10. NAME OF FATHER: Nephi Owens
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Elizabeth Campbell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): St Louis Mo

14. Informant: W T McGinnes
(Address): Bruneau Ida

15. Filed 9-22, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1929, to Sept 20, 1929.
that I last saw her alive on Sept. 20, 1929
and that death occurred, on the date stated above, at 11:55 P.m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(operation performed for relief of pelvic adhesions & massive varicosities of pelvic vessels) (duration) ... yrs. ... mos. 4 ds.
CONTRIBUTORY (Secondary): Rheumatic Heart Disease & auricular fibrillation.
? (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Sept. 14.
Was there an autopsy? no
What test confirmed diagnosis? Laboratory.
(Signed) Gerald T. Nokes, M. D.
Sept 21, 1929 (Address) 403 Eastman Bldg. Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bruneau Cemetry
Date of Burial: 9-23 1929

20. Undertaker: Schreiber & McCann
Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67732

Dr. H.T. Nokes
Boise

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Elizabeth Jane McGinnes who died Sept. 20, 1929
Cause of death given as "Cerebral Hemorrhage." "Rheumatic Heart disease and Auricular Fibrulation."

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Gentlemen:

Operation performed for the relief of pelvic adhesions and massive varicosities of the pelvic vessels.

Signed:

Herald T. Nokes

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67733

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 242

(No. St Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Jane Fowler

(a) Residence. No. ..... St. Star Idaho 100a

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or ~~Divorced~~ (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 20 - 1840

7. AGE 89 Years | Months 8 | Days 0 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Payne

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Ella Bond

(Address) Oakgrove Oregon

15. Filed 9-21, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 20 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8, 1929, to Sept 20, 1929

that I last saw her alive on Sept 19th, 1929

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

1) Broncho-pneumonia on
2) Pneumococcic parotitis left

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Fracture neck femur left. fell over rug in home falling to floor causing fracture (duration) yrs. mos. 12 ds.

18. Where was disease contracted if not at place of death? Fracture at home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & lab. findings

(Signed) L. F. West, M. D.

9-21, 1929 (Address) 413 Eastman Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Star Cemetery | Date of Burial Sept 22 1929

20. Undertaker Summers & Krebs | Address Boise Idaho

In reference to the death certificate of:

Sarah Jane Fowler who died Sept. 20, 1929 No. 6 7733
Cause of death (contributory) given as "Fracture neck femur left."

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO WAS INVOLVED PLEASE NAME THE PLACE WHERE THE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Tripped over rug in her home falling to floor causing fracture neck of femur left.

L. F. West M.D.
Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67734

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 241

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emily Thresia Esperance 31 R

(a) Residence. No. 119 S. 5 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Esperance

6. DATE OF BIRTH (month, day and year): Nov. 6, 1883

7. AGE: Years 45, Months 10, Days 13, If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Garden Valley Idaho

PARENTS
10. NAME OF FATHER: Steve Youren
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Fr Eliza Carter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Louis Esperance
(Address) 119 S. 5 St Boise Idaho

15. Filed 9-21, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Sept 19, 1929
that I last saw her alive on Sept 19, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ✓
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Physical & Laboratory Test
(Signed) James H. Stewart, M. D.
Sept 20, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Sept 23 1929

20. Undertaker: Summers & Krebs
Address: Boise Ida

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67735

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 1064
Local Registrar's No. 200

(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joe St. Laurent

(a) Residence. No. 910 Grove St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE: Years: about 71 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Logging Contractor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10. NAME OF FATHER: not obtained
11. BIRTHPLACE OF FATHER (city or town) (State or Country): "
12. MAIDEN NAME OF MOTHER: "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Leo E. Higgins
(Address) Coeur d'Alene Idaho

15. Filed 9/20, 1929 W. F. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 17th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18th, 1929 to Sept. 17th, 1929
that I last saw h— alive on Sept 17th, 1929.
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Cancer of stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? ✓ Date of
Was there an autopsy? No
What test confirmed diagnosis? Usual symptoms
(Signed) J. J. Spitzbarth, M. D.
Sept 19, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. John's Cemetery — Date of Burial: 9/20 1929
20. Undertaker: Schreiber & McCann — Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67736

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 239
(No. 111 S. 11th)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Simon Ahlers.

(a) Residence. No. ..... St. Patterson New Jersey
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Wilhelmina Ahlers.

6. DATE OF BIRTH (month, day and year) Nov. 26. 1863.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	9	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Office Manager
(b) General nature of industry, business, or establishment in which employed (or employer) of Oil Company
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Simon Ahlers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Lucia Kebel.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Mrs Simon Ahlers
(Address) 148 N Main St. Paterson N J

15. Filed 9-20, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 19 - 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ....., 19..., to ....., 19...
~~that I last saw him~~ alive on ..... 19...
~~and that~~ death occurred, on the date stated above, at about 6 P.M.

The CAUSE OF DEATH* was as follows:
Died very suddenly.
Acute Heart Attack.
Had Chronic Heart disease
and was traveling for his
health.
(duration) yrs. mos.
CONTRIBUTORY (Secondary) Natural Causes.
(duration) yrs. mos.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) W. McMahon, Coroner M.D.
9/19/29, 19... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Portland Oregon.	Sept 22. 1929
20. Undertaker	Address
Summers & Trebs	Boise Ida

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67737

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 9+10
Primary Registration District No. 9+10
Local Registrar's No. 85

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William M. Huckba 90

(a) Residence. No. Eagle, Idaho St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Harriet E. Huckba

6. DATE OF BIRTH (month, day and year) 7/6/1864

7. AGE Years 65 Months 1 Days 29 ~~If LESS than 1 day, hrs. or min.~~

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER Maynard Bartlett Huckba
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Mary E. Farmer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Mrs Harriet E. Huckba
(Address) Eagle, Idaho.

15. Filed 9/8, 1929 Orrie Jackson Registrar
Eagle Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 5 — 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Sep 5, 1929
that I last saw him alive on Sep 4, 1929
and that death occurred, on the date stated above, at — A m.
The CAUSE OF DEATH* was as follows:
Myocardial Degeneration from Influenza
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Exhaustion
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms
(Signed) Fred A. Pettingill M. D.
9-6-29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Dry Creek Cemetery — Date of Burial 9/8/29 19

20. Undertaker W McBratney — Address Boise Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67738

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 9460
Primary Registration District No. 9460

Local Registrar's No. 54

(No. ..... If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Thomas B. Jones 89

(a) Residence. No. ..... Star, Idaho St.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. (Usual place of abode) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed or Divorced (which) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 13 1871

7. AGE

Years	Months	Days
58	2	13

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Boone County
(State or country) Arkansas

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) "
(State or Country)
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) "
(State or Country)

14. Informant Mrs. Ted Pulliam
(Address) Star, Idaho.

15. Filed 9/10, 1929 Orville Jackson Registrar
Emmett Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1929; to Sept 8, 1929
that I last saw h[illegible] alive on Aug 30, 1929
and that death occurred, on the date stated above, at 7:[illegible] m.
The CAUSE OF DEATH* was as follows: Malignant Tumor

(duration) Many yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No

(Signed) Ole Hall M. D.
9/10/29, 19 (Address) Star Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	9/10/29
20. Undertaker H. McCluskey	Address Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67739

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2167
Local Registrar's No. 5664
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Mary Agnes Carey 44a
(a) Residence. No. 1116 E. Clark St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Exact date unknown
7. AGE Years 70 Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Kingston Canada

PARENTS
10. NAME OF FATHER Patrick Doran
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Agnes O'neal
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant James D. Lowery
(Address) Pocatello

15. Filed 9/29, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec, 1928, to Sep 24, 1929
that I last saw her alive on Sep 24, 1929
and that death occurred, on the date stated above, at 7 30 a m.
The CAUSE OF DEATH* was as follows:
Endocarditis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Hailey Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. J. Raaf, M. D.
Sep 28, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View
Date of Burial Sept 26 1929
20. Undertaker Schumacher & Beasley
Address City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 14 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6744

Registered No. 117

Registration District No. 83

Primary Registration District No. 2160

1. PLACE OF DEATH

County of Bannock

City of Downey (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Newman DeVere Van Leuven

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: March 10 1870 (Month) (Day) (Year)

7. AGE: 59 Yrs. 6 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Duman Van Leuven

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Anna Larsen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mattie Bloxham
(Address) Downey Idaho.

15. Filed Oct. 10 1929 Mary C. Coffin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 15 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24. 1927, to Sept. 15 1929, that I last saw him alive on Sept 15 1929, and that death occurred on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis.
Interstitial.

(Duration) 2 Yrs. 3 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Hartigan M. D.
9-14 1929. (Address) Downey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Downey Idaho. DATE OF BURIAL: Sept 18 1929

20. UNDERTAKER: J. Guy Hansen ADDRESS: Inkom Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 14 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 83
Primary Registration District No. 2160
File No. 6274
Registered No. 116

1. PLACE OF DEATH
County of Bannock
City of Downey
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Almond
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: Sept (Month) 18 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 11 hrs. or 35 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ~
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Downey, Idaho

10. NAME OF FATHER Burton M. Almond

11. BIRTHPLACE OF FATHER (State or Country) Newton, Utah.

12. MAIDEN NAME OF MOTHER Sottie Anderson Norby

13. BIRTHPLACE OF MOTHER (State or Country) Union, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. M. Almond
(Address) Downey

15. Filed Oct 16 1929 Mary C. Coffin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929, to Sept 19 1929, that I last saw him alive on Sept 18 1929, and that death occurred on the date stated above, at 5.00 A.M.

The CAUSE OF DEATH* was as follows:
Congenital Atelectasis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Premature & Poorly Developed.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Hartogsun M. D.
9-19-1929 (Address) Downey, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Downey, Idaho. DATE OF BURIAL: 9-19-1929

20. UNDERTAKER ~ ADDRESS ~

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 14 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah

City of St. Maries

Registration District No. 32

Primary Registration District No. 2049

(No. St. Maries Hospital St.)

File No. 67742

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Doyle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word) Single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE 52 Yrs. Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Section Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): C. M. St. P. & P. Ry. Co.

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Records

(Address) St. Maries, Ida

15. Filed Sept 30 1929

Walter Boberg
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 30 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1929, to Sept 30 1929, that I last saw him alive on Sept 30 1929, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows: Coronary Thrombosis

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. A. Robins M. D.

10/1 1929 (Address) St. Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 7 days. In the State ..... yrs. ..... mos. 7 days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Ewan, Washington

19. PLACE OF BURIAL OR REMOVAL: St. Maries Ida

DATE OF BURIAL: Oct 8 1929

20. UNDERTAKER: Geo. Mitchell

ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24658

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67743

PLACE OF DEATH
County of Benewah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049

Local Registrar's No. 27

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Henrietta Cather Keeton

(a) Residence. No. Railroad Avenue St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Tacon Keeton

6. DATE OF BIRTH (month, day and year) Jan. 31 - 1852

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wife of John T. Keeton deceased.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Guysville Ohio
(State or country)

PARENTS

10. NAME OF FATHER John Cather

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Waynesburg, Green Co. Penn.

12. MAIDEN NAME OF MOTHER Catherine Ctor

13. BIRTHPLACE OF MOTHER (city or town) Waynesburg
(State or Country) Green Co. Penn.

14. Informant Wm. R Keeton — (
(Address)

15. Filed Sept 30, 1929 Walter Boberg
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1929, to Sept 14, 1929
that I last saw h[illegible] alive on Sept 14, 1929
and that death occurred, on the date stated above, at 9:10 A m.

The CAUSE OF DEATH* was as follows:
No particular disease
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) High blood pressure
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) G E Cole, M. D.
9/17, 1929 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Maries Ida	9-17 1929

20. Undertaker	Address
Geo Mitchell	St. Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67744

PLACE OF DEATH
County of Benewah
City of St. Maries
Registration District No. 37
Primary Registration District No. 2049
Local Registrar's No. 26
(No. 413)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs John Nichols
(a) Residence. No. 42 6th Street St.
(Usual place of abode)
Length of residence in city or town where death occurred. 21 yrs. 0 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	American	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of widow of Mr. John Nichols

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	Dec	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norwalk Ohio

PARENTS

10. NAME OF FATHER Fred Ruff
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Schweizerland Germany
12. MAIDEN NAME OF MOTHER Cory Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Schweizerland Germany

14. Informant Mrs Frank F Allen
(Address) St Maries Ida.

15. Filed Sept 30, 1929. Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to Aug 16, 1929, that I last saw h. alive on Aug 16, 1929 and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? What test confirmed diagnosis?

(Signed) [illegible] M. D.
Sept 30, 1929 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Maries Ida	Aug 18 1929
20. Undertaker	Address
Geo. Mitchell	St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 11 1929

PLACE OF DEATH
County of Bear Lake
City of Bloomington

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 53
Primary Registration District No.

DO NOT WRITE IN THIS SPACE
State File No. 67745

Local Registrar's No. 126

(No.) 1
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harriett Adelia Ward

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Thomas Ward

6. DATE OF BIRTH (month, day and year): Aug 21, 1877

7. AGE: 52 Years | Months: 1 | Days: 14 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Self.

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: Andrew Thompson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Harriett Walker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Thomas R. Ward
(Address) Bloomington Idaho

15. Filed 10-8, 1929 Mrs. J. S. Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 5, 1929, to Oct 5, 1929
that I last saw her alive on Sept 14, 1929
and that death occurred, on the date stated above, at 11.10A m.

The CAUSE OF DEATH* was as follows:
Carcinoma Sigmoid.
Flexure - Middle third
(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Findings

(Signed) C O Moore M. D.
Oct 6, 1929 (Address) Paris Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bloomington Idaho | Date of Burial: 10-7 1929
20. Undertaker: John Hulme | Address: Bloomington Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67746

Registration District No. 5-3
Primary Registration District No.
Local Registrar's No. 125

PLACE OF DEATH
County of Bear Lake
City of Bloomington
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Evan Orson Reese

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 26, 1913

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
16	6	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Lotwick L. Reese
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Francis Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wyoming

14. Informant X J. J. Reese
(Address) Bloomington Idaho

15. Filed 10-7, 1929 Mrs. J. S. Summers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27, 1929, to Oct 3, 1929
that I last saw him alive on Sept 15, 1929
and that death occurred, on the date stated above, at 1, PM. m.
The CAUSE OF DEATH* was as follows:
Paralysis / Hemiplegia / Left side complete
(duration) yrs. 1 mos. 4 ds.
CONTRIBUTORY (Secondary) Mitral Insuff & Rheumatism Acute Art
(duration) 3 yrs. 2 mos. 0 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) C E Moore M. D.
Oct 4, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bloomington Ida	10-5 1929
20. Undertaker	Address
John Hulsne	Ida. Bloomington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67748

PLACE OF DEATH
County of Bear Lake
City of Fish Haven #1

Registration District No. 55
Primary Registration District No.

Local Registrar's No. 2

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Hugh Findlay 90

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Cathrine Partington Findlay

6. DATE OF BIRTH (month, day and year) July 20, 1860

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Riverdale Ut.

PARENTS

10. NAME OF FATHER Hugh Findlay
11. BIRTHPLACE OF FATHER (city or town) (State or Country) new mill, Scottland
12. MAIDEN NAME OF MOTHER Catrine Partington Findlay
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Shipool Lancshire Eng.

14. Informant Mrs. Ernest Natalus
(Address)

15. Filed , 19 Hannah J. Nelson a. R. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH aug 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Heart trouble
no doctor at time of death
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
	Sept. 2 1929
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67749

Local Registrar's No. 143

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No.
Primary Registration District No.
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Tom Long

(a) Residence. No. 1010 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 35				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Not Known
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10. NAME OF FATHER " "
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant J. A. Taylor
(Address) Idaho Falls, Idaho

15. Filed Oct 9, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1929, to Oct. 7, 1929,
that I last saw h alive on 19
and that death occurred, on the date stated above, at 4-30 P m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia,
Acute Parenchymatous
Nephritis.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible], M. D.
10-9 1929 (Address) Idaho Falls Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho — Date of Burial: Oct 10 1929

20. Undertaker: Jack A. Wood — Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67750

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21V-0
Local Registrar's No. 142
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Cuyer

(a) Residence. No. 101a St. St. Paul - Minn.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 35 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Lineman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Minnesota

PARENTS

10. NAME OF FATHER: Michael Cuyer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Ellen Israel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pennsylvania

14. Informant: Connelly & McDevitt
(Address): St Paul Minnesota

15. Filed Oct 9, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1929, to Oct. 7, 1929
that I last saw him alive on Oct 7, 1929
and that death occurred, on the date stated above, at 4-30 p m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible] Ruston, M. D.
10-9, 1929 (Address) Ida Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Paul Minnesota — Date of Burial: Oct 12 1929
20. Undertaker: Jack A. Ward — Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67751

County of Bonneville
City of Idaho Falls
Registration District No.
Primary Registration District No.
Local Registrar's No. 181

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gordon William Pogge.

(a) Residence. No. 474-11 St. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

11B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 10 1914

7. AGE: Years 15 Months 5 Days 27. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sugar City Ida.

PARENTS

10. NAME OF FATHER: Ulrich C Pogge
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.
12. MAIDEN NAME OF MOTHER: Mary L Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Cokeville Wyo.

14. Informant: Mrs Mary L Pogge
(Address) Idaho Falls Ida.

15. Filed Oct. 9, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 6. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3, 1929, to Oct 6, 1929
that I last saw him alive on 19
and that death occurred, on the date stated above, at 1:00 P.M.
The CAUSE OF DEATH* was as follows:
Influenza—
Encephalitis
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Same
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms Physical
(Signed) H D Snider, M. D.
Oct 7, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls. Ida. Date of Burial: Oct. 9 1929

20. Undertaker: V. F. McHan. Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 10 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67752

County of Bonneville.
City of Idaho Falls
Registration District No.
Primary Registration District No.
Local Registrar's No. 1 A

(No. Idahh Falls L. D. S. Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 A

2. FULL NAME Robert Lee Bybee

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or WIFE of)~~ ~~XXXXXXX~~ Harriet Bybee

6. DATE OF BIRTH (month, day and year) May 4, 1838

7. AGE	Years	Months	Days	If LESS than 1 day,
	91	5	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana.

PARENTS

10. NAME OF FATHER Byram Bybee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Betsy Lane.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Mrs. Charley Poole
(Address) Rexburg, Idaho.

15. Filed Oct 7, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 4th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1929, to Oct 4, 1929
that I last saw h~~im~~ alive on Oct 4, 1929
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia.

(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Senility.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? —
What test confirmed diagnosis?
(Signed) W. R. Nast, M. D.
10/10, 1929 (Address) Rigby

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho.	10/7/29 19

20. Undertaker A B Eckersell — Address R Rigby

1C

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67753

PLACE OF DEATH

County of Bonneville

City of Idaho Falls.

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. Idaho Falls L. D. S. Hosp.)

Local Registrar's No. 179

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Samuel Stephen Later.

99B

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~XXXXXXXX~~ Helena Mary Later.

6 DATE OF BIRTH (month, day and year) March 14, 1864

7 AGE: Years 65 | Months 6 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpente r

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10 NAME OF FATHER: Peter Later.

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: Elizabeth Brown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England.

14 Informant: Mrs. S. S. Later

(Address) Rigby, Idaho.

15 Filed Oct 7, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: September (Month) 25th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1929, to Sept. 25, 1929, that I last saw him alive on Sept 23, 1929, and that death occurred, on the date stated above, at 8 P.M. m.

The CAUSE OF DEATH* was as follows: Empyema (Left,

(duration) yrs. mos. 49 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Rigby Idaho

Did an operation precede death? Yes Date of Sept. 4-29

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [signature], M. D.

Sept 27, 1929 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rigby, Idaho.

Date of Burial: 9/29/29 19

20. Undertaker: A B Eckersell

Address: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT. 10 1929

PLACE OF DEATH

County of Bonneville

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67754

Local Registrar's No. 17

2. FULL NAME Fred C. Burke

(a) Residence. No. Boise, Idaho St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Bone

6. DATE OF BIRTH (month, day and year): Dec 15 1884

7. AGE: Years 45 | Months 9 | Days 16 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Onondaga Michigan

PARENTS

10. NAME OF FATHER: Fred J. Burke

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Carrie Hogewell

13. BIRTHPLACE OF MOTHER ~~(city or town)~~ (State or Country): New York

14. Informant: Charles Burke

(Address): Boise Idaho

15. Filed Oct 3, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 1 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1929, to Nov 3, 1929, that I last saw h~~im~~ alive on Nov 3, 1929 and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Duration

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Michigan

Did an operation precede death? No Date of

Was there an autopsy? Yes What test confirmed diagnosis? Symptoms and Autopsy

(Signed) John C. Miller, M. D.

Oct. 3, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho	Oct 3 1929
20. Undertaker: Jack A. Wood	Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67756

Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. 176

PLACE OF DEATH

County of Bonneville.
City of Idaho Falls.
(No. L. D. S. Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Florence Louise Peterson.

(a) Residence. No. ..... St. Rigby, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Babe.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 8, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	5	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Babe
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clark, Idaho.

PARENTS

10. NAME OF FATHER Raymond Peterson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.
12. MAIDEN NAME OF MOTHER Mary Ellen Cleverley.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant [illegible] Peterson
(Address) Rigby, Idaho R. #2

15. Filed Sept 30, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 16th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 19..., to Sept 16, 1929
that I last saw her alive on Sept 16, 1929
and that death occurred, on the date stated above, at 13. m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia.
..... (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Valvular Heart Disease
..... (duration) ... yrs. 5 mos. ... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of ~~Sept 29~~
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W R Nest, M. D.
9/19, 1929 (Address) Rigby, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby Idaho.	Sept 17 1929
20. Undertaker	Address
A B Eckersell	Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67757

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No.
Primary Registration District No.
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

185

2. FULL NAME Merritt Newton Pack
(a) Residence. No. Idaho Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Nance Tolbert Pack

6. DATE OF BIRTH (month, day and year) May 1, 1856

7. AGE Years 73 Months 4 Days 24 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake City, Utah

PARENTS
10. NAME OF FATHER John Pack
11. BIRTHPLACE OF FATHER (city or town) (State or Country) St John Canada
12. MAIDEN NAME OF MOTHER Julia Ives
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Watertown New York

14. Informant Mrs Nance T. Pack
(Address) Idaho Falls R. F. D. #2

15. Filed Oct 30, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25, 1929, to Sept 27, 1929
that I last saw him alive on Sept 27, 1929
and that death occurred, on the date stated above, at 11 a. m.
The CAUSE OF DEATH* was as follows:
Perforated intestine from fall across irrigation ditch accidental
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Peritonitis
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? yes Date of Sept 25
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature] M. D.
9/28/29 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Salt Lake City
Date of Burial Oct. 1 1929

20. Undertaker Jack A. Wood
Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67758

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No.

Primary Registration District No.

Local Registrar's No. 174

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isaac Hill.

(a) Residence. No. 490 D St. St. 88a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white.

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 27 1857

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
72	6	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Fyr. Tyter Co.

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Amasa Hill.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Connecis

12. MAIDEN NAME OF MOTHER Ann D Pyle

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Conn.

14. Informant Mrs Leah M. Lee.
(Address) Idaho Falls Ida.

15. Filed Sept 24, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19, to ✓, 19

that I last saw him alive on ✓, 19

and that death occurred, on the date stated above, at 12 P.M. m

The CAUSE OF DEATH* was as follows:

Endo Cardilia

(duration) yrs. mos. ds

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) A. R. Sodenquist, M. D.

9/28/, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida

Date of Burial: 9/29 1929

20. Undertaker: V. F. McHan

Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67759

Local Registrar's No. 173

PLACE OF DEATH

County of Bonneville. Registration District No.

City of Idaho Falls Primary Registration District No.

(No. 62)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alice Louise Wright.

(a) Residence. No. 5 miles N. of Idaho Falls (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred life, mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 14 1929.

7. AGE — Years | — Months | 8 Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Ida.

PARENTS

10. NAME OF FATHER Hiram Wright

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Arkansas.

12. MAIDEN NAME OF MOTHER Lillian Rogers

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Hiram Wright

(Address) Idaho Falls Ida.

15. Filed Sept 23, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21, 1929, to Sept 21, 1929, that I last saw her alive on Sept 21, 1929, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Rheumatism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W F Kellaway M. D., M. D.

Sept 23, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: 8/23 1929

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67760

PLACE OF DEATH

County of Bonneville
City of Idaho Falls.

Registration District No.
Primary Registration District No.

Local Registrar's No. 172

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Evan McPherson.

(a) Residence. No. 280 - 10 St. St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

88B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma McPherson.

6. DATE OF BIRTH (month, day and year) Feb. 15-1844

7. AGE: Years 85 Months 7 Days 6. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER Andrew McPherson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.
12. MAIDEN NAME OF MOTHER Nancy McBain
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Mrs Emma McPherson
(Address) Idaho Falls Ida.

15. Filed Sept 21, 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14, 1929, to Sept 21, 1929
that I last saw him alive on Sept 20, 1929
and that death occurred, on the date stated above, at 1:20 a.m.
The CAUSE OF DEATH* was as follows: Myocarditis and Arterio Sclerosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) A. R. Godwyn M. D.
9/21, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: 8/24 1929

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67761

PLACE OF DEATH
County of Bonneville. Registration District No.
City of Idaho Falls. Primary Registration District No.
Local Registrar's No. 17

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry A. Sufelt. 129

(a) Residence. No. 646 — 11 St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male. 4. COLOR OR RACE: white. 5. Single, Married, Widowed, or Divorced (write the word): Widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 14 1850

7. AGE — Years: 79 | Months: 8 | Days: 6. | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired.
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10. NAME OF FATHER: Henry Sufelt Sr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York.
12. MAIDEN NAME OF MOTHER: Julia Ann Middaugh
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New York.

14. Informant: Mrs Ella Yoding.
(Address): Idaho Falls Ida.

15. Filed Sept 21, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 20. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept-7., 1929, to Sept 20, 1929
that I last saw him alive on Sept 10-1929
and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:
Arterio-Sclerosis
Chronic Nephritis
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hemiplegia
(duration) yrs. mos. 13 ds.

18. Where was disease contracted if not at place of death? V
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) [signature] M. D.
Sept 21, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shelby Idaho. Date of Burial: 8/23 1929

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67762

PLACE OF DEATH
County of Bonneville. Registration District No.
City of Idaho Falls, Primary Registration District No.
Local Registrar's No. 170

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James S. Ferrier. 91A

(a) Residence. No. 205 Emmerson. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): married.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: mrs James S. Ferrier.
6. DATE OF BIRTH (month, day and year): aug 16 1877
7. AGE: Years 52 | Months 1 | Days 0 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer & Surveyor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Dakota Co. Nebraska.

PARENTS
10. NAME OF FATHER: James Ferrier Sr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn State
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: mrs James Ferrier.
(Address): Idaho Falls Ida.
15. Filed Oct 11, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 16. 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1929 to Sept. 16, 1929
that I last saw h alive on Sept. 16, 1929
and that death occurred, on the date stated above, at 6.15 p. m.
The CAUSE OF DEATH* was as follows:
Aortic aneurism
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. A. Chipperfield M. D.
Sept. 17, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida — Date of Burial: 9/19 1929
20. Undertaker: F. F. McHan — Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67763

PLACE OF DEATH
County of Bonneville. Registration District No.
City of Idaho Falls. Primary Registration District No.
Local Registrar's No. 169

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edith Drake.

(a) Residence. No. Idaho Falls: Ida. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of widowed.

6. DATE OF BIRTH (month, day and year) Dec 1- 1887.

7. AGE	Years	Months	Days	If LESS than 1 day,
	41	9	13.	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer W. E Anderson

9. BIRTHPLACE (city or town) (State or country) Annis Idaho.

PARENTS

10. NAME OF FATHER Orson Drake.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden Utah.
12. MAIDEN NAME OF MOTHER Anna.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden.

14. Informant W. E. Anderson.
(Address) Idaho Falls Ida.

15. Filed Sept 16, 1929 O. Townsend Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw her alive on Sept. 14, 19 29
and that death occurred, on the date stated above, at p m.

The CAUSE OF DEATH* was as follows:
Unknown -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) O. Townsend M. D.
Sept 16, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Iona Idaho.	9/18 1929
20. Undertaker V. F. McHan	Address Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67764

PLACE OF DEATH

County of Bonneville

City of Idaho Falls.

Registration District No.

Primary Registration District No.

Local Registrar's No. 16 f

(No. L. D. S Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

205-a

2. FULL NAME Joseph Allen Hendrickson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white.

5. Single, Married, Widowed, or Divorced (write the word): married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Joseph A. Hendrickson

6. DATE OF BIRTH (month, day and year): April 21 - 1893

7. AGE: Years 36 | Months 2 | Days 24 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: (Gunnison Utah)

9. BIRTHPLACE (city or town) (State or country): Gunnison Utah

PARENTS

10. NAME OF FATHER: Iver Hendrickson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Gunnison Utah

12. MAIDEN NAME OF MOTHER: Christine Madsen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark.

14. Informant: L. C. Hendrickson.
(Address) Drummond Ida.

15. Filed Sept 16, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11, 1929, to Sept 15, 1929, that I last saw him alive on Sept 15, 1929 and that death occurred, on the date stated above, at 9 27 P m.

The CAUSE OF DEATH* was as follows:

Gas Bacillus Infection

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Compound fracture of Addens & Ulna - arm caught in thrashing machine (duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? Drummond Ida

Did an operation precede death? Yes Date of Sept 11 - 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. M. Cline M. D.

9/16, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashton Ida. Date of Burial: 9/17 1929

20. Undertaker: V. F. McHan Address: Idaho Falls Ida

RECEIVED MAR 1 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67764

Dr.C.M. Cline
Ida. Falls

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Joseph Allen Hendrickson who died Sept. 15, 1929
Cause of death given as "Gas Bacillus infection." "Compound fracture of radeus and ulner."

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO WAS INVOLVED PLEASE NAME THE PLACE WHERE THE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Threshing machine
Arm caught in machinery
Pendleton

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67765

PLACE OF DEATH
County of Cassia
City of Oakley

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nick Smith

(a) Residence. No. Oakley St. Ida
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

124

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	W-Cili	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 9 1874

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisc.

PARENTS

10. NAME OF FATHER Nicholas Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Sophia A Walker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Ashley Smith
(Address) Oakley Ida.

15. Filed 10-10, 1929 David M. Cowell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28th, 1929 to Sept 29, 1929
that I last saw him alive on Sept 28th, 1929
and that death occurred, on the date stated above, at 12:30 A.m.

The CAUSE OF DEATH* was as follows: Nephritis Acute

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic nephritis
Arteriosclerosis (duration) 12 mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) H. E Lampe M. D.
Oct 28, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Oct. 1 1929
20. Undertaker	Address
J J Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1929

FORM V. S. No. 2 Rev. 1918

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 34

Primary Registration District No. 2020

File No. 67766

Registered No. 17

County of Elmore

City of Mt Home

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ira Ellen Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White.	

6. DATE OF BIRTH: Sept (Month) 12 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Grant Jensen

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Leah Fesler.

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Grant Fesler
(Address) Mountain Home.

15. Filed Sept 19 1929 H. Andrews Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 162
Sept (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-12 1929 to 9-14-1929
that I last saw her alive on 9-13 1929
and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Congenital Pyloric Atresia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J E Evans M. D.
9-15-1929 (Address) Mtn Home Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Mountain Home	9-14 1929
20. UNDERTAKER	**ADDRESS**
G. S. Zochert	Mt Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M-1-19 RECEIVED OCT 14 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Mountain Home (No. ..... St.)

Registration District No. 34

Primary Registration District No. 2020

File No. 67767

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Matilda Jane Childs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: Jan (Month) 2 (Day) 1869 (Year)

7. AGE: 60 Yrs. 8 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Mitchell

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Mitchell

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James J. Childs

(Address) Mountain Home

15. Filed Sep 19 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 5 (Day) 1929 (Year) 140

17. I HEREBY CERTIFY, That I attended deceased from Sept. 4 1929 to Sept 5 1929 that I last saw her alive on Sept 6 1929 and that death occurred on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows: Hemorrhage brain over right fissure of Rolando

(Duration) — Yrs. — mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. P. Hamilton M. D.

9-6 1929 (Address) Mtn. Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home

DATE OF BURIAL: 9-8 1929

20. UNDERTAKER: G. C. Zacher

ADDRESS: Mt. Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 14 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Mountain Home (No. ..... , ... St.)

Registration District No. 34

Primary Registration District No. 2020

File No. 67768

Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Dixon Reed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Divorced (Write the word.)

6. DATE OF BIRTH: Aug (Month) 17 (Day) 1838 (Year)

7. AGE: 91 Yrs. ..... Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: George Reed.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Dixon.

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ora Cannon

(Address) Mountain Home

15. Filed Sept 19 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 2 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1929, to Sept 1929 that I last saw him alive on Sept. 1 1929, and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows: Arterio Sclerosis (of Arteries)

..... (Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T E Evans M. D.

..... 19 ..... (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home

DATE OF BURIAL: 9-5 1929

20. UNDERTAKER: G. P. Zacher

ADDRESS: Mt Home

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. RECEIVED OCT 14 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Mountain Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34

Primary Registration District No. 2020

(No. ..... St.)

File No. 67769

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willis Alexander Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 6th (Day) 1865 (Year)

7. AGE: 64 Yrs. 6 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Fairfield Benton Co. Missouri

10. NAME OF FATHER: J. H. Johnson

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Lucinda Potter Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs E. W. Latimore

(Address) Mountain Home

15. Filed Sep 2 1929 [signature] ~~Local~~ Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 21 (Day) 1929 (Year) 44

17. I HEREBY CERTIFY, That I attended deceased from June 1 1929, to Aug 21 1929 that I last saw him alive on August 22 1929 and that death occurred on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T E Evans M. D.

8-31-1929 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Mountain Home

DATE OF BURIAL: 5-23 1929

20. UNDERTAKER: G. C. Zacher

ADDRESS: Mt. Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25-M. 1-19 RECEIVED OCT 14 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Mountain Home (No. ..... St.)

Registration District No. 34

Primary Registration District No. 2020

File No. 67770

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rufus Martin Fisher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Jan. (Month) 10 (Day) 1850 (Year)

7. AGE: 79 Yrs. 6 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Rufus Fisher

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Olive Martin

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harriett E. Fisher

(Address) Mountain Home

15. Filed Sept 2. 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 49

August (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1929, to Aug. 7, 1929, that I last saw him alive on Aug 7 1929, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. E. Evans M. D.

8-15-1929 (Address) Mtn. Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Mountain Home

DATE OF BURIAL: 8-9 1929

20. UNDERTAKER: G. C. Zucker

ADDRESS: Mt Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67771

PLACE OF DEATH

County of Freemont
City of Ashton

CERTIFICATE OF DEATH

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

2. FULL NAME Bealance Louise Mae Johnson

(a) Residence. No. St. 9
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female
4 COLOR OR RACE white
5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug 11 - 1928

7 AGE Years 1 Months 1 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Dakota

PARENTS
10 NAME OF FATHER Melvin Johnson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Nebraska
12 MAIDEN NAME OF MOTHER Mary Shultz
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Minn.

14 Informant Melvin Johnson
(Address) Le Grande Ore

15 Filed 9/22 1929 C.C. Meacham Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. (Month) 21 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Seen after death 9/21/29
that I last saw h alive on 19
and that death occurred, on the date stated above, at 10 a.m.
The CAUSE OF DEATH* was as follows: D.K. - Possibly Whooping Cough
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) ✓
✓ (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? D.K.
Did an operation precede death? no Date of ✓
Was there an autopsy? no.
What test confirmed diagnosis? none
(Signed) C.C. Meacham M.D.
9-22, 1929 (Address) Ashton, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Le Grande Ore
Date of Burial 19

20. Undertaker Lewis F. Hoser
Address Ashton

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67772

PLACE OF DEATH
County of Fremont
City of Ashton

CERTIFICATE OF DEATH
Registration District No. 102
Primary Registration District No. 6
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Robert Coslley

(a) Residence. No. ..... St. 112
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Apr 28-1927

7 AGE: Years 2 | Months 5 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ashton Idaho.

PARENTS
10 NAME OF FATHER: Grand Coslley
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ext Anthony
12 MAIDEN NAME OF MOTHER: Fern Bean
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Utah

14 Informant: Grant Coslley
(Address) Ashton Ida

15 Filed 10-9, 1929 C. C. Meacham, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 10 (Month) 8 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 10-7-, 1929, to 10-8-, 1929
that I last saw h~~e~~ alive on 10-8-, 1929,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
D.K. Possibly Acute Indigestion
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) D.K.
..... (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? at home.
Did an operation precede death? no. Date of —
Was there an autopsy? no.
What test confirmed diagnosis? none.
(Signed) C. C. Meacham, M. D.
10-9, 1929 (Address) Ashton, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Parker Idaho
Date of Burial: 10/10 1929

20. Undertaker: Lewis J Fiser
Address: Ashton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 14 1929

PLACE OF DEATH

County of Jerome

City of Eden

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67773

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hannah Curtiss Phillips

(a) Residence. No. Eden, Ida St. 164
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of George W. Phillips

6. DATE OF BIRTH (month, day and year) June 9

7. AGE Years 82 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER J. Stokesbury

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Salvina Reynolds

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Mary E. Edwards
(Address) Eden Ida.

15. Filed 10-8-, 1929. David M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1924, to Oct 5, 1929

that I last saw her alive on about Apr 1, 1929

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows: Senility - Has been bd ridden for past three years. Myocarditis also contributory

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. L. Berry M.D.

10-5, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery

Date of Burial: 10-6 1929

20. Undertaker: White Mortuary Inc

Address: Twin Falls Ida.

WRITE PLAINLY, WITH [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67774

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 30
Primary Registration District No. 2129
Local Registrar's No. 20

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME Alvin Parker Nicholson
(a) Residence. No. Winchester Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 20 1929

7. AGE Years Months 3 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winchester

PARENTS
10. NAME OF FATHER Erick C. Nicholson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Edna M Wood
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Erick C. Nicholson
(Address) Winchester Ida

15. Filed 9/28, 1929 R E Duncan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 25 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25, 1929, to Sept 25, 1929 that I last saw him alive on Dead When I Saw him and that death occurred, on the date stated above, at Morning m.

The CAUSE OF DEATH* was as follows: The Mother found the Body Dead on Arising in the Morning.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Mal-Nutrition - Thymus!

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) John F. Gist M. D.
9/25, 1929 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Cuniquinn Ida
Date of Burial Sept 26 1929

20. Undertaker Clyde Clouse
Address Cuniquinn Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 11 1929

PLACE OF DEATH

County of Lewis

City of Craigmont

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 50

Primary Registration District No. 2129

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67775

Local Registrar's No. 19

2. FULL NAME Leander Jackson Lockridge

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Emma Nancy Lockridge

6. DATE OF BIRTH (month, day and year) Jan. 8 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	8	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer, Retired

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Warren Co., Iowa

PARENTS

10. NAME OF FATHER William Lockridge

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Elizabeth Simmons

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant M. R. Lockridge

(Address) Craigmont, Idaho.

15. Filed 9/24/29, 19 [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1929, to Sept 21, 1929, that I last saw h[illegible] alive on Sept 20th, 1929 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis and chronic endocarditis

(duration) 9 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. A. Woodcock, M. D.

9-21-, 1929 (Address) Cottonwood

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F. Cemetery Craigmont, Idaho.	Sept. 24 1929
20. Undertaker	Address
Star Hdwe. & Impl Co.	Craigmont

RECEIVED OCT 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67776

PLACE OF DEATH

County of Lewis
City of Winchester

Registration District No. 60
Primary Registration District No. 2/29
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 18

161B

2. FULL NAME Moore

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of - - - - - - - - - - - - -

6. DATE OF BIRTH (month, day and year) August 24 1929

7. AGE Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winchester

PARENTS

10. NAME OF FATHER Hile Gene Moore
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oregon
12. MAIDEN NAME OF MOTHER Ruby Esther Gaynard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant Hile G. Moore
(Address) Winchester

15. Filed ~~8/24/29~~ 9/7-29 19 R. E. Dunlop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug-23, 1929, to Aug/24, 1929
that I last saw him alive on Aug/24 1929
and that death occurred, on the date stated above, at 1:15 P. m.
The CAUSE OF DEATH* was as follows:
Intra Cranial Hemorrhage (Traumatic). 5 hours.
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) R. O. P. Position Forceps Delivery (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) John F. Gist, M. D.
..... 19 (Address) Winchester Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cuignmi Idaho | Date of Burial: Aug/24 1929

20. Undertaker: Clyde Clovis | Address: Cuignmi Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67777

PLACE OF DEATH

County of Minidoka
City of Heyburn

Registration District No. 19
Primary Registration District No. 2015
(No.)
Local Registrar's No. 4

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harry L Beaty

(a) Residence. No. / St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Minnie L Beaty

6. DATE OF BIRTH (month, day and year) Mar. 22 1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	61	6	12	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Amanda Goodrich.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Minnie L Beaty
(Address) Heyburn Ida

15. Filed 10 8, 1929. Ed Edmunds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from None, 19.., to None 19..
that I last saw him alive on None, 19..
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Acute heart attack
Aortic Stenosis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Joseph Neustadt, M. D.
, 19.. (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Heyburn Ida	Oct 7 1929
20. Undertaker	Address
H.C. Johnson	Burley

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 11 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Minidoka

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... , ... St.)

File No. 67778

Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ira Vernon Lower

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 18 (Day) 1890 (Year)

7. AGE: 39 Yrs. 3 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Painter.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Plymouth Indiana

10. NAME OF FATHER: Ira Lower.

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Minnie ~~Bruce~~ Crist.

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edna May Lower

(Address) East St. Louis Ill.

15. Filed 10-1 1929 E. H. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 30 (Day) 1929 (Year) 49

17. I HEREBY CERTIFY, That I attended deceased from Sept. 18 1929, to Sept. 30 1929, that I last saw him alive on Sept. 30 1929, and that death occurred on the date stated above, at 7:20 P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Arterio-sclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) E. H. Elmore M. D.

10-2-1929 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: East St Louis Ill.

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Rodney G. Goodman

ADDRESS: Rupert.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
N is very important. See instruction on back of certificate.

RECEIVED OCT 14 1929

PLACE OF DEATH

County of Twin Falls,

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 2085

(No. County General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67779

Local Registrar's No. .....

143

2. FULL NAME Walter L. Rowen

(a) Residence. No. Hansen, Idaho. Route #2 St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 30th. 1885

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	8		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colo

PARENTS

10. NAME OF FATHER James L. Rowen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont know

12. MAIDEN NAME OF MOTHER Martha Murhpy

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs. Helen Rowen

(Address) Hansen Ida. Route #2

15. Filed 10-10-, 1929 David M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 30 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 19 29, to Sept 30, 19 29

that I last saw ~~he~~ alive on Sept 30, 19 29

and that death occurred, on the date stated above, at 2 2 m.

The CAUSE OF DEATH* was as follows:

Gun shot wound in neck (accidental)

(duration) ..... yrs. ..... mos. 16 hrs ..... ds.

CONTRIBUTORY (Secondary) Embolism

(duration) ..... yrs. ..... mos. ? ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Jas Davies, M. D.

9-30, 19 29 (Address) Kimberly Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Idaho.	Oct 2Nd. 19 29

20. Undertaker	Address
P.J.Grossman	Twin Falls, Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 1080

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67780

Local Registrar's No. .....

2. FULL NAME Mary Ellen Hills

(a) Residence. No. ..... County Hospital 116
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 18 / 1926

7. AGE: Years 3 | Months 4 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: Fred. A. Hills

11. BIRTHPLACE OF FATHER (city or town) (State or Country): S Dakota

12. MAIDEN NAME OF MOTHER: Gladys Clemans

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): S Dakota

14. Informant: Fred. A. Hills
(Address) Twin Falls

15. Filed 10 - 8, 1929. David D. Cowgill, Registrar

MEDICAL CERTIFICATE OF DEATH

Dr Alexander

16. DATE OF DEATH: Sept (Month) 28 (Day) 1925 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18th, 1929, to Sept, 1929 that I last saw her alive on Sept 23th, 1929 and that death occurred, on the date stated above, at 11-40 a.m.

The CAUSE OF DEATH* was as follows: Acute Intestinal Intoxication

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) —

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Farrell, M. D.

Sept 28, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls | Date of Burial: Sept 30 1929

20. Undertaker: F. L. Drake | Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67781

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1080
Local Registrar's No.
(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Catherine E. Dinkelacker

(a) Residence. No. 228 7th Ave N St. Hailey 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Feb 24 1856
7. AGE: Years 73 | Months 6 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Penn
PARENTS
10. NAME OF FATHER: Adolph
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Sophia Schaffer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany
14. Informant: Harry Dinkelacker
(Address) Twin Falls
15. Filed 10-8-, 1929. David McCowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 21 1929 8.15
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 14, 1929, to Sept 21, 1929
that I last saw her alive on Sept 20 1929
and that death occurred, on the date stated above, at 8:15 a. m.
The CAUSE OF DEATH* was as follows: Cardio vascular renal disease with hypertension
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary): Cerebral Hemorrhage
(duration) yrs. mos. 3 ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis? Physical Exam. & History
(Signed) George C. Hadley M. D.
Sept 23, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Sept 23 1929
20. Undertaker: T. E. Drake — Address: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67782

RECEIVED OCT 14 1929

PLACE OF DEATH

County of Twin Falls
City of Filer
Registration District No. 37
Primary Registration District No. 2086
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

148 C

2. FULL NAME J. Wesley Stephens

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 21 1918

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
11	1	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER W C Stephens
11. BIRTHPLACE OF FATHER (city or town) Ramos
(State or Country)
12. MAIDEN NAME OF MOTHER Cytha Barr
13. BIRTHPLACE OF MOTHER (city or town) Mo
(State or Country)

14. Informant W C. Stephens
(Address) Filer

15. Filed 10-8, 1929 David M. Cowgill
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 25 4:30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Auto accident
Skull. Crushed
(duration) yrs. mos. ds.
CONTRIBUTORY by wheel
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J C Drake, M. D.
, 19 (Address) County Coroner Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal — Date of Burial
Filer Cemetery — Sept 29 1929

20. Undertaker — Address
J C Drake Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 14 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67783

County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alfred Peters Junior

(a) Residence. No. 143 - W. Addison St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 21 - 1924

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4	8	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Twin Falls. Ida.
(State or country)

PARENTS

10. NAME OF FATHER Alfred Peters
11. BIRTHPLACE OF FATHER (city or town) Waupun Wis
(State or Country)
12. MAIDEN NAME OF MOTHER Johnna Mae Standlee
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Arkansas

14. Informant Alfred Peters
(Address) 143 - W. Addison

15. Filed 10 - 8, 1929 David M. Cowgill
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1929, to Sept 18, 1929
that I last saw h~~im~~ alive on Sept 18, 1929
and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:
Surgical Shock
Operation to cover burned area - died 1 hr after operation.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Burn of left arm
(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes no Date of Sept 18 / 29
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Dr J R Morgan M. D.
Sept 19, 1929 (Address) Twin Falls, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	9-20 1929
20. Undertaker	Address
White Mortuary Inc	Twin Falls. Ida

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67784

PLACE OF DEATH
County of Twin Falls
City of "

Registration District No. 31
Primary Registration District No. 2080
(No. Co Gen Hosp)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Edgar James Algire

(a) Residence. No. 237 7th East St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of: Jennie Algire

6. DATE OF BIRTH (month, day and year): April 1 1883

7. AGE: Years 46 | Months 5 | Days 16 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Brick mason
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Mo.

PARENTS

10. NAME OF FATHER: James Algire
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: Mary Doty
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Mrs Jennie Algire
(Address) 237 7th Ave East Twin Falls

15. Filed 10-8, 1929 David M Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 22, 1929, to Sept 17, 1929, that I last saw him alive on Sept 17, 1929, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 6 ? yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Serologic & clinical

(Signed) J M Davis M. D.
Sept 18, 1929 (Address) Kimberly Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sheldon Mo.	19
20. Undertaker	Address
P. J. Grossman	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67785

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 31
Primary Registration District No. 1085 Local Registrar's No.
Cty Hospital
(No. .....
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Geo W Perrine
(a) Residence. No. Blue Lake Blvd St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 17 / 1904

7. AGE Years: 25 Months: 4 Days: — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10. NAME OF FATHER: S. D. Perrs
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Marguerite Safuns
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: S. D. Perrine
(Address) Twin Falls

15. Filed 10-8, 1929 David M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929, to Sept 17, 1929
that I last saw him alive on Sept 17, 1929
and that death occurred, on the date stated above, at 3 30 p. m.
The CAUSE OF DEATH* was as follows: Hemothorax due to punctured left lung due to fractured ribs and pulmonary concussion caused by auto accident
(duration) ..... yrs. ..... mos. 1½ hrs.
CONTRIBUTORY (Secondary) Shock - accident occurred in City of Twin Falls.
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) George L. Halley M. D.
Sept 17, 1929 Deputy Coroner (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: Sept 20 1929

20. Undertaker: F. E. Drake
Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 30 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67785

Dr. Geo. C. Halley
Twin Falls, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Geo. W. Perrine who was killed in an auto accident at Twin Falls, Idaho on Sept. 17, 1929.

Information DESIRED in order to complete certificate:

WILL YOU PLEASE STATE WHERE THE ACCIDENT OCCURRED, I.E., COUNTY AND CITY OR TOWN. DID IT OCCURR WITHIN THE CITY LIMITS OR ON THE HIGHWAY?

PLEASE ANSWER BELOW:

The accident of George W. Perrine occurred in the city of Twin Falls, Idaho.

George C. Halley, M.D.

MAY 22 1930

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67786

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No. County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Norma Fay Watson

(a) Residence. No. St. 119
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 4 / 1927

7. AGE

Years	Months	Days	If LESS than 1 day,
2	7	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: S. C. Watson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Rena Phillips
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: S. C. Watson
(Address) Eden, Idaho

15. Filed 10 - 8, 1929 David M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11, 1929, to Sept 15, 1929
that I last saw her alive on Sept 14, 1929
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows: Entero Colitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) George C. Hafley M. D.
Sept 17, 1929. (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: Sept 18 1929

20. Undertaker: T. E. Drake
Address: T Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67787

County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 2086.
Local Registrar's No.
(No. Twin Falls County Hospital.) 14-0
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Zeta Myrtle Cammack

(a) Residence. No. Filer, Idaho. St. Filer, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Earl Cammack

6. DATE OF BIRTH (month, day and year) Sept., 30, 1888

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	11	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington

PARENTS

10. NAME OF FATHER Edson Sturgeon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Harrison
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Earl Cammack
(Address) Filer, Idaho

15. Filed 10-8, 1929. David M. Cowgill
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1929, to Sept 16, 1929
that I last saw h-- alive on Sept 16, 1929
and that death occurred, on the date stated above, at 10 4 m.

The CAUSE OF DEATH* was as follows:
Sepsis (Puerperal)
Labor past due
Cesarian Section
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Floating baby, Prolapsed cord
Abdom.-powers labor attempt.
(duration) yrs. mos. ds.
15 # 6 1/2 oz baby.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 9th/29
Was there an autopsy? No
What test confirmed diagnosis? Phys. diag.

(Signed) John R Morgan, M. D.
9/16, 1929 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Twin Falls, Idaho	
20. Undertaker	Address
White Mortuary, Inc	Twin Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 14 1929

PLACE OF DEATH

County of Twin Falls.

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

(No. Twin Falls County Hospital

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67788

Local Registrar's No.

2. FULL NAME Cordelia Joubin

(a) Residence. No. Twin Falls. Ida K.T. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Peter Joupin

6. DATE OF BIRTH (month, day and year) Dec 1-

7. AGE	Years	Months	Days	If LESS than 1 day,
	66	9	12	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montreal

PARENTS

10. NAME OF FATHER Tousin Masta

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montreal

12. MAIDEN NAME OF MOTHER Odelia Bonami

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montreal

14. Informant Peter Joupin

(Address) Twin Falls. Ida

15. Filed 10 - 8, 1929 David M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4th, 1929, to Sept 12, 1929

that I last saw her alive on Sept 12, 1929

and that death occurred, on the date stated above, at 3p m.

The CAUSE OF DEATH* was as follows:

Leukemia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage Intestinal

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? ~~v~~

Did an operation precede death? No Date of ~~v~~

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Bureau & Bureau M. D.

9/13/29 19 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	9-14 1929
20. Undertaker	Address
White Mortuary Inc	Twin Falls. Ida

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67789

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1082
(No. 161A)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Richardson

(a) Residence. No. 251 Fifth East, St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	X XXXXXX

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 9th. 1929

7. AGE	X Years	X Months	1 Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED X X XXXXXX XX
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Twin Falls, Idaho

PARENTS

10. NAME OF FATHER Wallace Richardson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.
12. MAIDEN NAME OF MOTHER Perl Reynolds
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Wallace Richardson
(Address) 251 Fifth Ave Esat Twin Falls,

15. Filed 10-8, 1929 David M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9, 1929 to Sept 10, 1929
that I last saw h[illegible] alive on Sept 10, 1929
and that death occurred, on the date stated above, at 4 A M.
The CAUSE OF DEATH* was as follows:
Prematurely Delivered at 7 mos gestation)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No What test confirmed diagnosis? Physical Findings
(Signed) George C. Halley M. D.
Sept 11, 1929 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Idaho — Date of Burial: Sept. 10 1929

20. Undertaker P.J. Grossman — Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67790

PLACE OF DEATH

County of Twin Falls,
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1080
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

49

2. FULL NAME Beri Vance
(a) Residence. No. Twin Falls, Id a . Route # 2 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Dec. 1St.1864

7. AGE: 64 Years | 9 Months | 7 Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10. NAME OF FATHER: Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Dont know
12. MAIDEN NAME OF MOTHER: Dont know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dont know

14. Informant: John Vance
(Address): Route #2 Twin Falls, Idaho

15. Filed 10-8-, 1929 David M Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 8 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1929, to Sept 8th 1929
that I last saw him alive on Sept 7th 1929
and that death occurred, on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Cancer of Prostate

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John T Coughlin M. D.
9-12, 1929. (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls, Idaho | Date of Burial: Sept 12 1929

20. Undertaker: P.J.Grossman | Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67791

PLACE OF DEATH
County of Washington
City of Weiser Ida

Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 15

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rachel Catherine Odomy 57

(a) Residence. No. West Third St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 17th [illegible] 1853

7. AGE 76 Years 4 Months 16 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wilmington Ohio

PARENTS
10. NAME OF FATHER John Milliken
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Millikan.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14. Informant Joseph N Odomy
(Address) Weiser Idaho

15. Filed Oct 3rd, 1929 W. R. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3rd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8 . 15 . 1921, to 10 3 1929, that I last saw her alive on 10 . 3 . 1929 and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Diabetic Mellitus

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene Sev. Sinistra

(duration) yrs. mos. 20 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Gen. Examination

(Signed) Ernest O. Finney, M. D.
10/4, 1929 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Gibbons. Nebr. Date of Burial 19

20. Undertaker L. C. Northam Address Weiser Ida

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67792

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 47
Primary Registration District No. 1010
Local Registrar's No. 14
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leora Marie Preston

(a) Residence. No. 14 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 27 1926

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	11	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Wilder
(State or country) Idaho

PARENTS

10. NAME OF FATHER Elmer A. Preston
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Eunice C Campbell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Texas

14. Informant Elmer A. Preston
(Address) Midvale Idaho

15. Filed 9/27/ 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 27th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1929, to Sept 26, 1929
that I last saw h[illegible] alive on Sept 26, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:

Dysentery.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. W. Marshall, M. D.
, 19 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Midvale Ida.	9-28 1929
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67793

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 7-2
Primary Registration District No. 1110

Local Registrar's No. 13

(No. 490)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Conrad Lund

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
7	11	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Walter Lund

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Anna Wavrich

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Colorado

14. Informant Walter Lund
(Address) Weiser Ida

15. Filed Sept 23, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929, to Sept. 22, 1929
that I last saw him alive on Sept. 22, 1929
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Endocarditis acute

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Tonsil Infection Probably Staph aureus Virulent (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) F. A. Schmidt M. D.
Sept 23, 1929 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hill Crest Cemetery	9-24 1929
20. Undertaker L. C. Moorhouse	Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1929

PLACE OF DEATH

County of Wash.

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1110

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 67794

Local Registrar's No. 12

164

2. FULL NAME Harriet Delaney Gordon

(a) Residence. No. 903 State St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word): Widowed

5a. ~~If married~~, widowed, ~~or divorced~~ ~~HUSBAND of~~ ~~(or)~~ WIFE of Alexander A. Gordon

6. DATE OF BIRTH (month, day and year) May 21 - 1844

7. AGE: Years 84, Months 3, Days 27. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Saranac Michigan

PARENTS

10. NAME OF FATHER: Beckwith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....

12. MAIDEN NAME OF MOTHER: Hannah Fay

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Southborough Mass.

14. Informant: Howard H. Gordon

(Address) Weiser Idaho

15. Filed Sept-19th, 1929 W. R. Hamilton
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1929, to Sept 18, 1929 that I last saw her alive on Sept. 14, 1929 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

senility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? age

(Signed) F. A. Schmitz M. D.

Sept. 19, 1929 (Address) Weiser I.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hillcrest Cemetery — Date of Burial: 9-20-1929

20. Undertaker: L. C. Northam — Address: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67795

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

164

2. FULL NAME Sarah A Harris
(a) Residence. No. Midvale Idd St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of J. H. Harris

6. DATE OF BIRTH (month, day and year)

7. AGE 86 Years | Months 2 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Mrs Ethel Felinek
(Address) Midvale Idd

15. Filed Sept 8th, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept. 7, 1929
that I last saw her alive on Sept 7th, 1929
and that death occurred, on the date stated above, at 7.30 P. m.
The CAUSE OF DEATH* was as follows:
Senile Debility

(duration) 1 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of /
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) C. C. Conant, M. D.
9/7/29, 19 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery | Date of Burial 9-8 1929
20. Undertaker L. C. Northam | Address Weiser Idd

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

V6

DO NOT WRITE IN THIS SPACE
State File No. 67796

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. .....
Primary Registration District No. 1010

Local Registrar's No. 10

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Terry Buckber

(a) Residence. No. 1107 N 8th St St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

164

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	married

5a. If married, widowed, or divorced
HUSBAND of
(or ~~WIFE of~~ Mary E. Buckber

6. DATE OF BIRTH (month, day and year) Dec 28-1847

7. AGE	Years	Months	Days	If LESS than 1 day,
	81	8	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Genrl Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) W Va.

PARENTS

10. NAME OF FATHER James Buckber

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va.

12. MAIDEN NAME OF MOTHER Robinson Outlys

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Va

14. Informant Mary E. Buckber
(Address) Weiser Idaho

15. Filed Sept-5, 1929 W. R. Hamilton
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to Sept 2, 1929
that I last saw ~~him~~ alive on Sept 2, 1929
and that death occurred, on the date stated above, at 12 a m.
The CAUSE OF DEATH was as follows:
senility
unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? general symptoms
(Signed) G M Waterhouse M. D.
Sept 5, 1929 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal	Date of Burial
Hillcrest Cemetery	9-6-1929
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67797

PLACE OF DEATH

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 1010

Local Registrar's No. 9

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Lewis Jeffreys

(a) Residence. No. ..... St. 74a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE Wht

5. Single, Married, Widowed, or Divorced (write the word) divorced

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Racheal B. Jeffreys

6. DATE OF BIRTH (month, day and year) April 1 1856

7. AGE 73 Years | Months 3 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Stockman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Woodson Jeffreys

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Sarah Jane Forrest

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Mrs Alice Hitsman

(Address) Weiser Idaho

15. Filed Aug 16, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 14th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 11th, 1929, to Aug 14th, 1929

that I last saw him alive on Aug 14th, 1929

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Paralysis of Bladder.

..... (duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. R. Hamilton, M. D.

Aug 15th, 1929 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery | Date of Burial Aug. 17th 1929

20. Undertaker L. C. Northam | Address Weiser Ida

67798

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67798

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 254
(No. St Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Willis M Warner

(a) Residence. No. Yellowstone Rooms St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1851

7. AGE — Years: 78 | Months: 8 | Days: 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Huskel Jones
(Address) Hamilton Hotel Boise Ida

15. Filed 10-1, 1929 W. F. Rhodes Registrar
R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9- (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-29, 1929, to 9-30, 1929
that I last saw him alive on 9-29, 1929
and that death occurred, on the date stated above, at 3:00 a.m.
The CAUSE OF DEATH* was as follows:
Mesenteric thrombosis
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) several yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yellowstone Rooms
Did an operation precede death? No Date of
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy findings
(Signed) Lyman F. West, M. D.
9-30, 1929 (Address) 413 Eastman Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sperry Funeral Home — Date of Burial: Oct 1 1929
20. Undertaker: Summers & Kelly — Address: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 21 1929

67799

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67799

PLACE OF DEATH
County of Bannock
City of POCATELLO, IDAHO

Registration District No. 78
Primary Registration District No. 3161
(No. Pocatello Gen Hosp
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5668

2. FULL NAME Delmer C. Eggert
(a) Residence. No. POCATELLO, IDAHO St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

189

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Married
6. DATE OF BIRTH (month, day and year): Oct 5, 1898
7. AGE: 30 Years, 11 Months, 25 Days. If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Stacewelle Iowa

PARENTS
10. NAME OF FATHER: L. E. Eggert
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wisconsin
12. MAIDEN NAME OF MOTHER: Rose Baeff
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Chicago Ill

14. Informant: Mrs. D. C. Eggert
(Address) POCATELLO, IDAHO
15. Filed Sept 30, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: POCATELLO, IDAHO Sept (Month) 29 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 9-26, 1929, to 9-29, 1929
that I last saw him alive on 9-29, 1929
and that death occurred, on the date stated above, at 7:10 P. m.
The CAUSE OF DEATH* was as follows:
Ruptures of spleen caused by horse falling n him (duration) ... yrs. ... mos. 4 ds.
CONTRIBUTORY (Secondary)
... (duration) ... yrs. ... mos. ... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 9-26-29
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature], M. D.
Sept 30, 1929 (Address) POCATELLO, IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mason City, Iowa
Date of Burial: Sept 30 1929
20. Undertaker: McHan Undt Co
Address: POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67[illegible]

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. Idaho Soldiers Home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Orange S. Hinds 99

(a) Residence. No. Soldiers Home St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1847

7. AGE Years 82 Months 0 Days 0 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Veteran of
(b) General nature of industry, business, or establishment in which employed (or employer) Civil War.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant E G Burnet
(Address) Soldiers Home, Boise Idaho

15. Filed 10-1, 1929 W. H. Rhodes R. S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to 10/1, 1929
that I last saw him alive on 10/1, 1929
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) ~~Asterio~~ - Coronary Thrombosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical History
(Signed) Fred A Pettengill, M. D.
10/1, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery — Date of Burial Oct 3 1929

20. Undertaker Summers & Krebs — Address Boise Idaho

67802

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67802

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No.

PLACE OF DEATH

County of Ada.
City of Boise.
(No. 409 Thatcher street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME La Martine Cretors

(a) Residence. No. 409 Thatcher St.
(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

129

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna Cretors.

6. DATE OF BIRTH (month, day and year) February 18th 1875

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	7	28	----------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Aurora, Illinois.

PARENTS

10. NAME OF FATHER J. H. Cretors.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Mary Cretors.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant J. H. Cretors.
(Address) ~~Boise, Idaho.~~

15. Filed 10-16-1929 W. T. Rhoades Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 16th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Oct 16, 1929
that I last saw him alive on Oct 15, 1929
and that death occurred, on the date stated above, at 1:30 A.M.
The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) A. B. Bonds, M. D.
10/16/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	10/18/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 23 1929

67803

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67803

Registration District No. 16
Primary Registration District No. 16
Local Registrar's No. 5

PLACE OF DEATH
County of Lincoln
City of Shoshone
(No. Burdett Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Russell Owen Robinson

(a) Residence. No. Boise, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. — yrs. — mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Zelma Irene

6. DATE OF BIRTH (month, day and year) July 1 1899

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
30	##	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Right of Way Agent
(b) General nature of industry, business, or establishment in which employed (or employer) For Mountain States Telephone Co.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebo, Ill

PARENTS

10. NAME OF FATHER F. A. Robinson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebo Ill.
12. MAIDEN NAME OF MOTHER Maggie Pennock
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Griggsville Ill

14. Informant Zelma Robinson, Wife
(Address) Boise Idaho.

15. Filed Oct 25, 1929 J. L. Turner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 15, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11, 1929, to Oct 15, 1929
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 1.50 a.m.

The CAUSE OF DEATH* was as follows:
Concussion of Brain with Cerebral Hemorhage
Car Accident
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X Ray & Phy Exam

(Signed) F E Barrett, M. D.
Oct 15, 1929 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Boise Idaho	
20. Undertaker	Address
E. E. Hickok	Shoshone Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 28 1929

67804

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67804

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 45

(No. 101a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Edward Russell

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Dorothy Ethel Russell

6. DATE OF BIRTH (month, day and year) Aug. 14, 1896

7. AGE	Years	Months	Days	If LESS than 1 day,
	33			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER J. R. Russell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Laudie Cager
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs. Thomas E. Russell
(Address) Kellogg, Idaho Box 945

15. Filed Oct. 29, 1929 Mrs. Helen M. O'Brien Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 18, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16, 1929, to Oct 18, 1929
that I last saw h[illegible] alive on Oct 18, 1929
and that death occurred, on the date stated above, at 10:45 A.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Geo. T. Kinnell M. D.
Oct 19, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sandpoint, Idaho	Oct 17 1929
20. Undertaker M. P. Thornhill	Address Kellogg, Idaho

67805

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67805

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 1004
(No. 521 Grove)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Valentine Letemendi Misso

101a

(a) Residence. No. 521 Grove St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Canoto Misso

6. DATE OF BIRTH (month, day and year): Dec. 14, 1903

7. AGE: Years 25 | Months 10 | Days 20 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nevada

PARENTS
10. NAME OF FATHER: Antonio Letemendi
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Spain
12. MAIDEN NAME OF MOTHER: Leandra Ondarra
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Spain

14. Informant: Joe Letemendi
(Address)

15. Filed 11-8, 19 W. H. Rhodes R. S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/1, 1929, to 11/4, 1929
that I last saw her alive on 11/4, 1929
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar.
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Pulmonary T. B.
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms
(Signed) Fred A. Patenger M. D.
11/6, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Johns Cemetery | Date of Burial: 11/6 1929
20. Undertaker: Schreiber & McCann | Address: Boise Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 1-24 M. L. 19. RECEIVED OCT 31 1929

67806

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jerome

City of Jerome

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18

Primary Registration District No.

(No. , St.)

File No. 67806

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donald M Foote

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 25 (Day) 1853 (Year)

7. AGE: 76 Yrs. 4 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Building Contractor

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Adjodnidas Foote

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. L. Foote

(Address) Jerome

15. Filed 10/17 1929

Chas F Zeller
JMC Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1929, to Oct 14 1929 that I last saw him alive on Oct 12 1929, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Influenza (intestinal)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Prostatitis

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) Wm F Schmershall M. D.

Oct 16 1929 (Address) Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Idaho

DATE OF BURIAL: 10/17 1929

20. UNDERTAKER: D. A. L. Harrison

ADDRESS: Jerome Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Book.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67807

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 293

2. FULL NAME Melvin Nichols
(a) Residence. No. 2711 W. 26 St.
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. mos. ds.
(If nonresident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

101B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov-9-1844

7. AGE: Years 85, Months 0, Days 1
If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Attorney
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: John Nichols
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mass
12. MAIDEN NAME OF MOTHER: Mary Chase
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mass

14. Informant: Horace W. Nichols
(Address) R D # 2 Boise Idaho

15. Filed 11-12, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 10th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7th, 1929, to Nov 10th, 1929
that I last saw him alive on Nov 10th, 1929
and that death occurred, on the date stated above, at 4:30 P.m.
The CAUSE OF DEATH* was as follows:
Senile pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Senility & Hypertension
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Book M. D.
Nov 12th, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Nov 12 1929

20. Undertaker: Summers & Krebs
Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67808 (67808)
Local Registrar's No. 86

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
(No. U. S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Flavius J. BROBST

(a) Residence. No. Boise, Idaho St. 90
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6. DATE OF BIRTH (month, day and year) unknown

7. AGE	Years	Months	Days	If LESS than 1 day,
about 85 xx				hrs. or min.

8. OCCUPATION OF DECEASED unknown
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) unknown
(State or country) Ark

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (city or town) unknown
(State or Country)

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant M. Cornelius
(Address) U. S. Veterans' Bureau, Boise, Idaho

15. Filed 11/13, 1929 W. R. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 8, 1929, to November 9, 1929
that I last saw him alive on November 9, 1929
and that death occurred, on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:
Acute cardiac dilatation
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) arteriosclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F. C. Smith, Reg. Med. Officer M. D.
11-12-29, 19 (Address) U.S.Vet.Bureau Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	11-15-29 19
20. Undertaker	Address
Wm. McBratney	Boise, Idaho

67809

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67809

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 290

(No. St. Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

32

2. FULL NAME Mitsuko Kurihara

(a) Residence. No. 714 Main St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Japanese

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) July 23-1921

7. AGE Years 8 Months 3 Days 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell, Ida

PARENTS

10. NAME OF FATHER Seikuro Kurihara

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan

12. MAIDEN NAME OF MOTHER Fuyuo Yoshihara

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Japan

14. Informant Seikuro Kurihara.
(Address)

15. Filed 11-8, 1929 W. H. Rhodes Registrar
R. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 5th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 23, 1929, to Nov 5th, 1929

that I last saw her alive on Nov 5th 1929

and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows: Tuberculose Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Bock M. D.

Nov 5th, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 11/8 1929

20. Undertaker: Schneyba & McCann — Address: Boise, Ida

Dr. Bock

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

67810

RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67810

PLACE OF DEATH

County of Minidoka
City of Rupert

CERTIFICATE OF DEATH

Registration District No. 19
Primary Registration District No. 2015
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 54

2. FULL NAME Fredrick J. Richards

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1488a

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. 30, 1871

7 AGE: Years 57 | Months 10 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work R. R. Conductor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer O. S. L. R. R.

9 BIRTHPLACE (city or town) (State or country) Osage Iowa

PARENTS
10 NAME OF FATHER Samuel Richards
11 BIRTHPLACE OF FATHER (city or town) (State or country) Iowa
12 MAIDEN NAME OF MOTHER Elnora Crome
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Vanola Couslanger
(Address) Pocatello Idaho

15 Filed Nov. 11, 1929 E. H. Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 12 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Rail Road Accident,
(Fell + Ran over by cars)
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) W. A. Goodman, ~~M. D.~~
Rupert Idaho Oct 13 1929 (Address) Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Pocatello Idaho
Date of Burial: Oct 24 1929

20. Undertaker: H. L. McHan
Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.....

Registration District No.....

Primary Registration District No.....

Local Registrar's No.....

PLACE OF DEATH

County of Minidoka

City of Rupert

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fredrick J Richards

(a) Residence. No..... St.....

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 30th I87I

7. AGE	Years	Months	Days	If LESS than 1 day,
	57	I0	I0	.....hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work R R Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer O S L R R Co

9. BIRTHPLACE (city or town) Osage Iowa
(State or country)

PARENTS

10. NAME OF FATHER Samuel Richards

11. BIRTHPLACE OF FATHER (city or town) Osage Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Elnora Crome

13. BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or Country)

14. Informant Vanola Couslanger

(Address) Pocatello Idaho

15. Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct I2th I929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Killed By train

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. G. Graham, M.D.

....., 19..... (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello Idaho	Oct I4 1929

20. Undertaker	Address
H L McHan	Pocatello Idaho

RECEIVED NOV 16 1929

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

W.A. Goodman
Coroner

Dear [redacted]: Mr. Goodman

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

Fredrick J. Richards who died Oct. 12, 1929 from a Railroad accident.

Information DESIRED in order to complete certificate.

The date of birth and age by years, months and days. If this is unknown will you please give us the approximate age of this man. This is very urgent as we have a request for a certified copy awaiting your reply.
PLEASE ANSWER BELOW

Rupert Idaho
Nov I5 I929
Department Of Public Welfare
Dear Sirs

As per your request I am sending you copy of death Certificate of Fredrick J Richards acopy of death Certificate was Mailed to Pocatello at the time of death and I supposed it wuuld be sent to your office also made one for R R Co one to Dr Elmore and a statement to Citizens Bank Pocatello in regard to this Perticular death Any servive I can do for You in any of the matters I will glad do it .

Very Truly Yours
Coroner Minidoka County
W. A. Goodman

RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67811

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 107

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Barbara Jelotta Gillam 74B

(a) Residence. No. 1505 N-8th St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 5 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William E. Gillam

6. DATE OF BIRTH (month, day and year) Nov.-3-1906

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
22	10	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Loveland
(State or country) Colorado

PARENTS

10. NAME OF FATHER James H. Grewell
11. BIRTHPLACE OF FATHER (city or town) Iowa City
(State or Country) Iowa
12. MAIDEN NAME OF MOTHER Madge Fougate
13. BIRTHPLACE OF MOTHER (city or town) Viola
(State or Country) Illinois

14. Informant William E. Gillam
(Address) Boise Ida.

15. Filed 10-14-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 to, 1929, to Oct 11, 1929
that I last saw her alive on Oct 11, 1929
and that death occurred, on the date stated above, at 2-15 a.m.
The CAUSE OF DEATH* was as follows:
Carditis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism
(duration) ~~yrs. mos. ds.~~ 12 hrs

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W L Frazier, M. D.
, 19 (Address) Boise - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Loveland, Colo
Date of Burial: 19

20. Undertaker: G. V. Peckham
Address: Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67812

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 271

PLACE OF DEATH

County of Ada
City of Boise
(No. St Alphonsus Hospital. 13 R)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Edward Moore

(a) Residence. No. 1020 E. Bannock St.
(Usual place of abode)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Alta Moore

6. DATE OF BIRTH (month, day and year) April 11 1867

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	6	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Foreman for
(b) General nature of industry, business, or establishment in which employed (or employer) Boise Water Co.
(c) Name of employer

9. BIRTHPLACE (city or town) Ohio
(State or country)

PARENTS

10. NAME OF FATHER Edward Moore
11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14. Informant Mrs. J. E. Moore
(Address) 1020 E. Bannock St Boise Idaho

15. Filed 10/14, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9- 1929, to Oct. 14- 1929.
that I last saw him alive on Oct 14 1929
and that death occurred, on the date stated above, at 9 15 a.m. m.

The CAUSE OF DEATH* was as follows:
Ascending Transverse Myelitis
& Bulbar Paralysis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Ascending Transverse Myelitis
(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam.
(Signed) W. Fred T. Rhodes, M. D.
10-14-, 1929 (Address) 402 Eastman Bldg Boise Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Oct 16 1929
20. Undertaker	Address
Summers & Reed	Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Dr. [illegible]

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67813

PLACE OF DEATH

County of Ada

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 270

(No. 1216 N. 14th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Mrs. Julia Elizabeth Allen

(a) Residence. No. 1216 N. 14th Street. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: William B. Allen

6. DATE OF BIRTH (month, day and year): January 13th 1849

7. AGE: Years 80 | Months 8 | Days 29 | If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Chester, Illinois.

PARENTS

10. NAME OF FATHER: Samuel Anderson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Eliza W. Askins.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn.

14. Informant: Mrs. Wm. Pohlman.
(Address) Boise, Idaho.

15. Filed Oct 12, 1929 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 12th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Sep 1st, 1929, to Octbr 12th, 1929 that I last saw her alive on Octbr 11th, 1929 and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

Duration 7 days.—

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility and Hypertension (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Baatz M. D.

10/12/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Chester, Illinois | Date of Burial: Shipped 10/13/29 19

20. Undertaker: Wm. McBratney. | Address: Boise, Idaho.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67814

PLACE OF DEATH

County of Ada

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 269

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

149

2. FULL NAME Gerald Lynn Harris.

(a) Residence. No. Eagle, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): White.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) April 13th 1920

7. AGE

Years	Months	Days	If LESS than 1 day,
9	5	21	---------- min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work In School.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Eagle, Idaho.

PARENTS

10. NAME OF FATHER William David Harris.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Alice Fewkes.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant Harvey Harris.

(Address) Eagle, Idaho.

15. Filed 10-10, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 4th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929, to Oct 4, 1929

that I last saw him alive on Oct 4, 1929

and that death occurred, on the date stated above, at 12:45A.M m.

The CAUSE OF DEATH* was as follows: Accident Fractured Skull (Kicked in the head by a horse)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Findings

(Signed) Alfred Busby E Jr. M. D.

10/4/29, 19 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 10/6/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67815

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 268

2. FULL NAME Josephine Rein

(a) Residence. No. 1015 W. 5 St. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or ~~Divorced~~ (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 7 - 1848

7. AGE Years 81 Months 1 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER John H. Tennyson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Nancy Maxwell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant John G. Breckenridge
(Address) R5 Boise Idaho

15. Filed 10-7, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4, 1929, to Oct 7, 1929
that I last saw her alive on Oct 6 1:30 P.M. 1929
and that death occurred, on the date stated above, at 1,40 P.M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H. M. Holverson, M. D.
Oct 7, 1929 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Oct 8 1929

20. Undertaker: Summers & Krebs
Address: Boise Idaho

Town

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67816

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 267

PLACE OF DEATH

County of Ada

City of Boise

(No. St Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elmer John Miller

(a) Residence. No. ~~20~~ 208 Jefferson St. 161a

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 6, 1929

7. AGE: Years | Months | Days | If LESS than 1 day, 15 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise Idaho

PARENTS

10. NAME OF FATHER: Cecil J. Miller

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Twin Falls Idaho

12. MAIDEN NAME OF MOTHER: Clara Merrill

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Boise Idaho

14. Informant: Cecil J. Miller

(Address) 208 Jefferson St. Boise Idaho

15. Filed 10-7, 1929 W. J. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 6 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4 a m Oct 6, 1929 to 5 a m Oct 6, 1929

that I last saw him alive on Oct 6, 1929

and that death occurred, on the date stated above, at 5 a m m.

The CAUSE OF DEATH* was as follows: Premature Birth

(duration) One hour. yrs. mos. ds.

CONTRIBUTORY (Secondary) None known.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. R. Lowe, M. D.

Oct 6, 1929 (Address) 215 1st Nat Bank Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Oct 7 1929

20. Undertaker: Summers & Tubs. — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 7 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67817

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 266

(No. St. Alphonsus Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Mary E. Newland.

(a) Residence. No. 305 E. Jefferson St. 90

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. A. Newland.

6. DATE OF BIRTH (month, day and year) Sept. 29th ~~1828~~ 1887

7. AGE	Years	Months	Days	If LESS than 1 day,
~~41~~	42	0	6	---- hrs. or ---- min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Santaquin, Utah.

PARENTS

10. NAME OF FATHER Phillip H. Cushing.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City, Utah.

12. MAIDEN NAME OF MOTHER Phoebe Nisesonger.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St. Louis, Mo.

14. Informant J. A. Newland.

(Address) Boise, Idaho.

15. Filed 10-7, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 5th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1929, to Oct. 5, 1929

that I last saw h-- alive on Oct 5, 1929

and that death occurred, on the date stated above, at 1 P.M m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular
Cardiac asthma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical symptoms

(Signed) Fred A Albright, M. D.

10/7/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pocatello, Idaho. Date of Burial Shipped 10/7/29 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

Bacc

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67818

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 265

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maxine Juanita Whitney.

(a) Residence. No. 1518 State St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) June 16th 1910

7. AGE: 19 Years; Months: 3; Days: 18; If LESS than 1 day, ---------- hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: In shhool.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise, Idaho.

PARENTS

10. NAME OF FATHER: Howard H. Whitney.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Mabelle G. Burnside.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Muscatine, Iowa.

14. Informant: Katherine F. Whitney.
(Address) Boise, Idaho.

15. Filed 10-7, 1929, W. H. Rhodes, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 4th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Octbr 2nd, 1929, to Octbr 4th, 1929 that I last saw her alive on Octbr 4th, 1929 and that death occurred, on the date stated above, at 10:30 PM.

The CAUSE OF DEATH* was as follows: Peritonitis following a ruptured appendix -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Appendicitis -

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

10/5/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 10/6/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67819

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 263

2. FULL NAME Hester B. Fountain

(a) Residence. No. ..... St. ..... 118 B
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: John L. Fountain

6. DATE OF BIRTH (month, day and year): Feb. 18. 1869

7. AGE: Years 60, Months 7, Days 17. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Meigo Co Ohio

PARENTS
10. NAME OF FATHER: John Bacus
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: x x x x x x
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: T. L. Fountain
(Address) Meridian Id.

15. Filed 10-5, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16, 1929, to Oct 4, 1929
that I last saw her alive on Oct 4-10 A.M., 1929
and that death occurred, on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows: Intestinal obstruction.

..... (duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary): Carcinoma ovary
..... (duration) 1½ yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? Yes Date of Oct 3, 1929
Was there an autopsy? No
What test confirmed diagnosis? operative findings
(Signed) Lyman F West, M. D.
10-5, 1929 (Address) 413 Eastman Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery — Date of Burial: Oct. 6. 1929

20. Undertaker: W. S. Moteis — Address: Meridian Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67820

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 262

2. FULL NAME Ruth F. Hammelrath

(a) Residence. No. ..... St. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

31

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Walter Hammelrath

6. DATE OF BIRTH (month, day and year) Aug 20, 1901

7. AGE Years 28 Months 1 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Wm. Milliken
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mont Knoll Missouri
12. MAIDEN NAME OF MOTHER Augusta Snyder
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mont Knoll Missouri

14. Informant Walter Hammelrath
(Address) Meridian Ida

15. Filed 10-4, 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 3, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 27, 1929, to Oct 3, 1929
that I last saw her alive on Oct 3, 1929
and that death occurred, on the date stated above, at 4:30 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(duration) 3 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Tubercular
Pneumonia (duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? Ada County
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Sputum Ex
(Signed) J. H. Braxton, M. D.
Oct 4, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Ida
Date of Burial: 10-6 1929

20. Undertaker: B. W. Robison
Address: Meridian Idaho

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67821

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 261

2. FULL NAME Edward Lindsay Chapman

(a) Residence. No. 618 State St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

49

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie M Chapman

6. DATE OF BIRTH (month, day and year): Sept. 23 - 1865

7. AGE: 64 Years | Months | Days: 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Banking
(c) Name of employer: James A Murray

9. BIRTHPLACE (city or town) (State or country): Boise Idaho

PARENTS

10. NAME OF FATHER: George Chapman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Minnie A Gillespie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Hong Kong China

14. Informant: Carrie M Chapman
(Address) (Temporary) 618 State

15. Filed 10-3, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from for 20 minutes, 19..., to ....., 19...
that I last saw him alive on Oct 2, 1929
and that death occurred, on the date stated above, at 3 p m.
The CAUSE OF DEATH* was as follows:
Angina pectoris

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Geo Collister, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Portland, Ore
Date of Burial: Shipment Oct. 4 1929

20. Undertaker: Schreiber & McCann
Address: Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Almond

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67822

Registration District No. 3
Primary Registration District No. 1004
Local Registrar's No. 260

PLACE OF DEATH
County of Ada
City of Boise
(No. St Lukes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marjorie J. Kuhns

(a) Residence. No. 101a St. Huntington Ore.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 9 ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of C A Kuhns

6. DATE OF BIRTH (month, day and year) May 29 1894

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35	4	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Albany N. Y.

PARENTS

10. NAME OF FATHER Edward H Sharkey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Yorks
12. MAIDEN NAME OF MOTHER Jessie P Fisher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New Yorks

14. Informant C A Kuhns
(Address) Box 273 Huntington Oregon.

15. Filed 10-3, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to Oct 1, 1929
that I last saw her alive on Sept 30, 1929
and that death occurred, on the date stated above, at 8 p m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Asthma
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Boise.
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? X ray
(Signed) H W Edmund, M. D.
10-2, 1929 (Address) Boise.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Johns	10-3 1929
20. Undertaker Eckreter & McCann	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Pitt

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67824

PLACE OF DEATH

County of Ada.

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 258

(No. Idaho State Soldier's Home.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Frund.

(a) Residence. No. Idaho State Soldier's Home. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

105

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Widower.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ----------

6. DATE OF BIRTH (month, day and year): February 27th 1850

7. AGE: Years 79, Months 7, Days 0. If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Indian War Veteran.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Switzerland.

PARENTS

10. NAME OF FATHER: Unknown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Switzerland.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Switzerland.

14. Informant: Pearl Allen.
(Address) Boise, Idaho.

15. Filed 10-3, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 27th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 10/1, 1928, to 9/27, 1929

that I last saw him alive on 9/26, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(duration) yrs. mos. ds.

CONTRIBUTORY Micardial Degeneration
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Fred A. Pittenger, M. D.

10/1/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 9/30/29 19

20. Undertaker: Wm. McBratney. — Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

Pet

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67825

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 257
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wayne Alfred Courson.
(a) Residence. No. ..... St. Baker Oregon
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept. 30, 1929
7. AGE Years Months Days If LESS than 1 day, 2 hrs. or 30 min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Boise Idaho

PARENTS
10. NAME OF FATHER Wayne Coleman Courson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Ina Elizabeth Budge
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Wayne C. Courson.
(Address) Baker Oregon % Shell Oil Co.
15. Filed 10-1, 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 30 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 9/30, 1929, to 9/30, 1929
that I last saw him alive on 9/30, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Inertia. Weight 2½ lbs. Undeveloped, but apparently full term (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? ✓ Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptom
(Signed) Fred A. Pittenger, M. D.
10/1/29, 19 (Address) Boise Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial Oct 1 1929
20. Undertaker Summers & Krebs
Address Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67826

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 614 ½)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 255

2. FULL NAME Jessie Phelps Coffin.

(a) Residence. No. 614 ½ State St.
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sherman M. Coffin

6. DATE OF BIRTH (month, day and year) July 3 1860

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	3	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS

10. NAME OF FATHER Orlando S. Phelps
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York.
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant Sherman M. Coffin
(Address) 614 ½ State St. Boise Idaho

15. Filed 10-1, 1929 W. N. Rhodes Registrar
R.R.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27, 1929, to Sept 27, 1929
that I last saw her alive on Sept 27, 1929
and that death occurred, on the date stated above, at 10, m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Breast.
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical findings
(Signed) [illegible], M. D.
Oct 1, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Oct 4 1929
20. Undertaker	Address
Summers & Krebs.	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 7 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. Idaho Soldiers Home.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67827

Local Registrar's No. 253

2. FULL NAME Henry H. Bailey

(a) Residence. No. Idaho Soldiers Home St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ella Simons

6. DATE OF BIRTH (month, day and year) Nov. 26, 1836

7. AGE	Years	Months	Days	If LESS than 1 day,
	92.	92	10	3 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York State

PARENTS

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant Gerard L. Cross.

(Address) 1818 Ellis St. Bellingham Wash

15. Filed 10-1, 1929 W. N. Rhodes Registrar

K. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 29. (Day) 1929. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Sep 29, 1929

that I last saw ~~him~~ alive on Sep 29, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? No Clinical Symptoms

What test confirmed diagnosis?

(Signed) Fred A Schwartz, M. D.

9/30, 1929 (Address) 1 Idaho Ave

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Sept. 30 1929
20. Undertaker	Address
Summers & Krebs	Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

PLACE OF DEATH

County of Ada

City of

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2034

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67828

Local Registrar's No. 80

2. FULL NAME Charles J. Wood

(a) Residence. No. 5 Miles West of Boise 124
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 21, 1854

7. AGE: Years 75 Months 5 Days 7 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: Jay Wood

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: J C Wood
(Address) Box 926. Boise Idaho

15. Filed 10-28, 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 10th, 1929, to Oct 28th, 1929
that I last saw him alive on Oct 27th, 1929
and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:
Nephritis (acute) accompanied with softening of brain and high blood pressure (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Boeth, M. D.

Oct 28th, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Oct 29 1929

20. Undertaker: Summers & Krebs — Address: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 7 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No. U. S. Veterans' Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67829

Local Registrar's No. 78

2. FULL NAME Donald F. HART

(a) Residence. No. Payette, Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

31

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Hart

6. DATE OF BIRTH (month, day and year) 4-1-1891

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs, or ..... min.
	38	6	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Post Officer clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Neb.

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant M. Cornelius

(Address) U. S. Vet. Bureau, Boise, Idaho

15. Filed 10-11, 19 29 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 10 19 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 15, 19 29, to October 10, 19 29
that I last saw him alive on October 10, 19 29
and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Tbc.pul.chr.act. far advanced "C"

Tbc. Laryngitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? xx

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy & Laboratory

(Signed) F.C. Smith, Reg. Med. Off., M. D.

10-11-29, 19 (Address) U.S. Vet. Bureau Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Payette, Idaho. Date of Burial Shipped 10/11/29 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67830

PLACE OF DEATH
County of Ada.
City of Boise.
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 77
(No. 2nd & Orchard Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Eva McGinnis

(a) Residence. No. 2nd & Orchard. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of J. D. McGinnis.

6. DATE OF BIRTH (month, day and year) April 19th 1868

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
61	5	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas.

PARENTS

10. NAME OF FATHER Unknown.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) W
12. MAIDEN NAME OF MOTHER W
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) W

14. Informant J. D. McGinnis.
(Address) Boise, Idaho.

15. Filed 10-3, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 29th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/1, 1929, to 9/29, 1929
that I last saw h alive on 9/29, 19
and that death occurred, on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH* was as follows:
Nephritis
(duration) 2 yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Uremic poisoning
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Urinalysis
(Signed) W R Fraser, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	10/1/29 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 7 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No. U. S. Veterans' Bureau, Boise, Idaho

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67831

Local Registrar's No. 76

1183

2. FULL NAME Sofus JENSEN

(a) Residence. No. Deer Park, Washington St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of xx

6. DATE OF BIRTH (month, day and year) 10-8-1891

7. AGE	Years	Months	Days	If LESS than 1 day,
	37	11	22	hrs. or min.

8. OCCUPATION OF DECEASED unknown

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER C. A. Jensen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant M. Cornelius

(Address) U. S. Vet. Bureau, Boise, Idaho.

15. Filed 10-2, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1929, to Sept. 30, 1929

that I last saw him alive on Sept. 30, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Abscess pelvis, 2 weeks

Intestinal obstruction, 1 week

General peritonitis, 1 week

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mechanical ileus

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-29-29

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy & Laboratory

(Signed) F. C. Smith, Reg. Med. Off., M. D.

, 19 (Address) U.S. Vet. Bureau, Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kalispell, Montana. Date of Burial: Shipped 10/2/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67832

PLACE OF
County of Ada RECEIVED NOV 7 1929
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 285
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Jane Call
(a) Residence. No. ..... St. 57 Salt Lake Utah
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 19 1862
7. AGE Years 67 Months 2 Days 8. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Israel Barlow
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Lucy Heap
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs. Fred Christensen
(Address) R. 4 Boise Idaho

15. Filed 10-28, 1929 W. F. Rhodes R.L. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27, 1929, to Oct 27, 1929
that I last saw her alive on Oct 27, 1929
and that death occurred, on the date stated above, at 2a m.
The CAUSE OF DEATH* was as follows:
Diabetic Coma -
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Finding's
(Signed) Alfred Budge Jr, M. D.
(Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bancroft Idaho. Date of Burial Oct. 29 1929
20. Undertaker Summers & Krebs Address Boise Idaho

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67833

PLACE OF DEATH

County of Ada
City of Boise Ida.

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Boise Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 284

2. FULL NAME Charles Avery Kingsley

(a) Residence. No. 716 Washington St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida A Kingsley

6. DATE OF BIRTH (month, day and year): October 12-1853

7. AGE: 76 Years | Months | Days: 11 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Parmer New York

PARENTS

10. NAME OF FATHER: Silas Kingsley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ~~Unknown~~ American
12. MAIDEN NAME OF MOTHER: Elmor Damorest
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ~~Austerwicke~~

14. Informant: Ida A Kingsley
(Address) 716 Washington St. Boise Ida.

15. Filed 10-26, 1929 W. H. Rhodes Registrar
K. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 21, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 21, 1929, to October 23, 1929 that I last saw him alive on October 22nd, 1929 and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:
Perforated ulcer of Duodenum

(duration) 40 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of October 21, 1929
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Harold W Stone, M. D.
10/25, 1929 (Address) Eastman Bldg, Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: 10/26 1929

20. Undertaker: Schreiber & McCann | Address: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
K. R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement [illegible] important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 7 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. St. Lukes)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67834

Local Registrar's No. 283

2. FULL NAME Mattie E Ross

(a) Residence. No. Boise 1920 N. State St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6. DATE OF BIRTH (month, day and year) Apr 3. 1855

7. AGE: Years 74 | Months 6 | Days 20 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Mississippi

PARENTS

10. NAME OF FATHER: Evans

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Robert M Rea

(Address) Meridian Ida

15. Filed 10-24 1929 W. J. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1929, to Oct 23, 1929

that I last saw her alive on Oct 23, 1929

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Gallstones + Cholecystitis

(duration) many yrs. 2 mos. 23 ds.

CONTRIBUTORY (Secondary) Acute Miocarditis

(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Boise, Idaho

Did an operation precede death? Yes Date of Oct 21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. M. Bradshaw, M. D.

Oct 24, 1929 (Address) Boise Idaho

Operation by Dr J S Springer

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery — Date of Burial: Oct 25 1929

20. Undertaker: [redacted] — Address: Meridian Ida

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67835

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 282

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wong Chung

(a) Residence. No. 706 1/2 Front St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

170

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Yellow
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1860

7. AGE Years 69 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laundry
(b) General nature of industry, business, or establishment in which employed (or employer) and
(c) Name of employer Gardner

9. BIRTHPLACE (city or town) (State or country) China

PARENTS
10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) China
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) China

14. Informant Wong
(Address) 6 1/4 Front St.

15. Filed 10-23, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct-20-1929. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19 , to , 19~~ ~~that I last saw him alive on , 19~~ ~~and that~~ death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Found Dead. Suicide. Shot himself in abdomen with 38 Smith & Wesson Revolver. (duration) yrs. mos. ds.

~~CONTRIBUTORY~~ (~~Secondary~~) No Inquest held. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) W. McBratney, Coroner, ~~M.D.~~

10-22, 1929 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Chinese Plot — Date of Burial 10/23 1929

20. Undertaker Morris Hill Schreiber & McCann — Address Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67836

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 28

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Benjamin Code

(a) Residence. No. 908 N. 10 St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliza Ann Code

6. DATE OF BIRTH (month, day and year): July 2-1849

7. AGE: Years 80 | Months 4 | Days 18 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10. NAME OF FATHER: Abraham Code
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Tithia James
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Mrs Benjamin Code
(Address) 908 N 10 St Boise Ada Co

15. Filed 10-22-1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18, 1929, to Oct 20, 1929
that I last saw h[illegible] alive on Oct 20, 1929
and that death occurred, on the date stated above, at 7:30 a m
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
(duration) yrs. mos 3 ds

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) A. B. Black, M. D
Oct 21, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Oct 22 1929
20. Undertaker: Summers & Krebs — Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

West.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67837

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1904
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 280

2. FULL NAME Reuben Bean Wright

(a) Residence. No. 912 Hays. St. 131
(Usual place of abode)
Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 12-1848

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	6	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Minister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10. NAME OF FATHER Elihu Wright
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont
12. MAIDEN NAME OF MOTHER Ruth Bean
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant W. D. McReynolds
(Address) 912 Hays st Boise Idaho

15. Filed 10-22, 1929 W. F. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3, 1929, to Death, 19...
that I last saw h... alive on Oct 19, 1929
and that death occurred, on the date stated above, at 9:45 a. m.
The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Postoperative postatelectasis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 9-12-29
Was there an autopsy? No
What test confirmed diagnosis? Physical + lab findings
(Signed) L. F. West M. D.
10-21, 1929 (Address) 4136 Latham Blvd

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Oct 22 1929
20. Undertaker	Address
Summers & Turbo	Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BIN...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

Lanbaugh

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67838

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1094
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 279

2. FULL NAME Eliza Jenkins
(a) Residence. No. 918 N. 7 St. 49
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced, (write the word): Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 23 - 1844
7. AGE Years 85 Months 1 Days 27 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER Joseph Harris
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Frank M Brashears
(Address) 918 N. 7 St. Boise Idaho
15. Filed 10-21, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) - 20 (Day) - 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 9-21-, 1927, to 10-20-, 1929
that I last saw her alive on 10/20/29, 19
and that death occurred, on the date stated above, at 11 00 m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Ernest E. Lanbaugh, M. D.
10/21, 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Caldwell Idaho
Date of Burial: Oct. 21 1929
20. Undertaker: Summers Krebs
Address: Boise Ida.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Fairbaugh

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67839

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 378

R

2. FULL NAME Loyd Wesley Sullivan

(a) Residence. No. 2103 N 14, St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Alta Mae Sullivan

6. DATE OF BIRTH (month, day and year): Jan-14-1910

7. AGE: Years 19, Months 9, Days 5. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Eagle Idaho

PARENTS

10. NAME OF FATHER: Edwin R. Sullivan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Alice G Freeman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Calif.

14. Informant: W. E. Sullivan
(Address) 114 N. 17 St Boise Idaho

15. Filed 10-21, 1929 W. H. Rhodes R.E. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) - 19 (Day) - 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-30-, 1929, to 10-19-, 1929
that I last saw him alive on 10-19-29, 19...
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
~~Broncho-Pneumonia~~
Streptococcus Sore Throat.
(duration) ... yrs. ... mos. 24 ds.
CONTRIBUTORY (Secondary): Broncho-Pneumonia
(duration) ... yrs. ... mos. 17 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? X Ray
(Signed) Ernest E. Fairbaugh M. D.
10/21, 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Oct 21 1929

20. Undertaker: Summers & Krebs
Address: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

Springer

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67841

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22

2. FULL NAME Jane Perkins Brasie
(a) Residence. No. 1503 Warm Springs Ave
(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

44

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of N Eugene Brasie

6. DATE OF BIRTH (month, day and year) March 9-1880

7. AGE: Years 49, Months 7, Days 7. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Virginia

PARENTS
10. NAME OF FATHER: Joseph Perkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Sarah Maupin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14. Informant N Eugene Brasie
(Address) 1503 Warm Springs Ave Boise Ida

15. Filed 10-19, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11, 1929, to Oct 16, 1929
that I last saw her alive on Oct 16th, 1929
and that death occurred, on the date stated above, at 2 30 p m.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) ✓
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) J S Springer, M. D.
Oct 17, 1929. (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Oct 18 1929

20. Undertaker: Summers & Krebs
Address: Boise Idaho

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67842

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1964
Local Registrar's No. 225
(No. St Lukes Hospital. 133)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jandrum Lynn Wiseman
(a) Residence. No. ____ St. Payette Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Alma Wiseman

6. DATE OF BIRTH (month, day and year): Feb. 22. 1893

7. AGE: Years 36. Months 7 Days 23 If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Shoeman
(b) General nature of industry, business, or establishment in which employed (or employer): ____
(c) Name of employer: ____

9. BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS
10. NAME OF FATHER: Benson Wiseman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina
12. MAIDEN NAME OF MOTHER: Margaret Wheeler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): North Carolina

14. Informant: Mrs. Margaret Hubert
(Address) Payette Idaho 421 S. 9th

15. Filed 10-19-1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to Oct 15th, 1929, that I last saw h alive on Oct 15th, 1929, and that death occurred, on the date stated above, at 11:45 p.m.

The CAUSE OF DEATH* was as follows:
Jaundice due to Cholangitis & Cholecystitis.
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) ____ yrs. ____ mos. 1 ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? Yes Date of Oct 8th 1929.
Was there an autopsy? No
What test confirmed diagnosis? ____

(Signed) J. S. Springer, M. D.
Oct 17, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Payette Idaho, Date of Burial: Oct 20 1929
20. Undertaker: Summers & Kirk, Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67843

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 274

2. FULL NAME Carlos Gossi

(a) Residence. No. 818 - Washington St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly Gossi

6. DATE OF BIRTH (month, day and year) Mar 31 - 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	6	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chiavenna Italy

PARENTS

10. NAME OF FATHER Thomas Gossi
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Chiavenna Italy
12. MAIDEN NAME OF MOTHER Mary Capridla
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Chiavenna Italy

14. Informant Vernon Gossi
(Address) Boise Ida

15. Filed 10-18, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1929, to Oct. 17, 1929
that I last saw him alive on Oct 16, 1929
and that death occurred, on the date stated above, at 12:40 A m.

The CAUSE OF DEATH* was as follows:
Perforation of intestine & other internal injury, accidental blow from a cow.
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Abscess of liver and of Lungs (duration) yrs. 2½ mos. ds.

18. Where was disease contracted if not at place of death? Ranch near Arrowrock
Did an operation precede death? Yes Date of Oct 15-29
Was there an autopsy? No
What test confirmed diagnosis? Examination & operation
(Signed) J Reno Number, M. D.
Oct 18, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Johns Cemetery	10-19 1929
20. Undertaker	Address
Lebreuber & McClain	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, FRACTIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

PLACE OF DEATH

County of Ada

City of Meridian

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67845

Registration District No.

Primary Registration District No.

Local Registrar's No. 11

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME ~~Ruth~~ Daisy Bailey

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6. DATE OF BIRTH (month, day and year): 9-21-29

7. AGE: Years | Months | Days | If LESS than 1 day, 1/2 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Meridian Idaho R2

PARENTS

10. NAME OF FATHER: Ottis V. Bailey

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Gantbury Okl.

12. MAIDEN NAME OF MOTHER: ~~Ruth~~ Ethel Ruth Lansing

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Ottis V. Bailey

(Address): Meridian R2 Idaho

15. Filed 9-22, 1929 H F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) - 21 (Day) - 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-21, 1929, to 9-21, 1929

that I last saw her alive on 9-21, 1929

and that death occurred, on the date stated above, at 8. P m.

The CAUSE OF DEATH* was as follows: Premature Birth between 5 & 6 month.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. F. Neal, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67847

PLACE OF DEATH

County of Ada

City of Meridian

Registration District No.

Primary Registration District No.

Local Registrar's No. 9

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jacob I Nisewaner 136

(a) Residence No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 28, 1872

7. AGE Years 57 Months 1 Days 10 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Elk City
(State or country) Kansas

PARENTS

10. NAME OF FATHER Samuel Nisewaner

11. BIRTHPLACE OF FATHER (city or town) Harpers Ferry
(State or Country) West Va

12. MAIDEN NAME OF MOTHER Mary Whiteside

13. BIRTHPLACE OF MOTHER (city or town) St Claire
(State or Country) Illinois

14. Informant Mrs. Emily Rice
(Address)

15. Filed 8-10, 1929 H. F. Neal
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 8th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-5, 1929, to 5-8, 1929

that I last saw ~~him~~ alive on 5-7-, 19

and that death occurred, on the date stated above, at 1:06 7 m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Obstruction of colon

(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. F. Neal, M. D.

5-9-, 1929 (Address) Meridian Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Meridian Idaho
Date of Burial: 5-9 1929

20. Undertaker: B W Robison
Address: Meridian Idaho.

REC... APR 4 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67847

Dr. H.F. Neal
Meridian, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Jacob I. Nisewaner who died at Meridian, Idaho on May 8, 1929
Cause of death given as "Peritonitis. Obstruction--------"

Information DESIRED in order to complete certificate:

PLEASE COMPLETE STATEMENT OF CAUSE. JUST OBSTRUCTION IS NOT ENOUGH.

PLEASE ANSWER BELOW:

Obstruction of Colon

H F Neal

JUN - 1 2000

RECEIVED NOV 5 [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67848

PLACE OF DEATH
County of Adams
City of Council, Idaho
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Mrs. Sarah Bowman

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of: Samuel Bowman

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 82, Months 5, Days 20. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Monroe Co. Ind.

PARENTS

10. NAME OF FATHER: John Kirby
11. BIRTHPLACE OF FATHER (city or town) (State or Country): North C.
12. MAIDEN NAME OF MOTHER: Betty Myers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N.C.

14. Informant: Mrs Ida Mahan
(Address): Council Idaho

15. Filed 10/31, 1929. W. M. Brown, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24, 1929, to Oct 28, 1929
that I last saw her alive on Oct 28, 1929
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. M. Brown, M. D.
, 19 (Address) Starkey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Baker Ore
Date of Burial: Oct 31 1929

20. Undertaker: West & Co
Address: Baker Ore.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67849

PLACE OF DEATH
County of Adams
City of New Meadows

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 101A)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Branstetter
(a) Residence. No. 6 miles from New Meadows St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 14 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White, American	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Married Helen Forbis Branstetter

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	2	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher & stock-raiser
(b) General nature of industry, business, or establishment in which employed (or employer) Farming
(c) Name of employer

9. BIRTHPLACE (city or town) Melville (State or country) Mo.

PARENTS
10. NAME OF FATHER Lafayette Branstetter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Jane McQuiston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Ward Branstetter
(Address) New Meadows, Idaho

15. Filed Oct 31, 1929. W. M. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 18th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 12, 1929, to October 18, 1929
that I last saw him alive on October 18, 1929
and that death occurred, on the date stated above, at 6:15 P. m.
The CAUSE OF DEATH* was as follows:
Double lobar pneumonia

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY —
(Secondary)
(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) W. M. Schuyler, M. D.
October 19, 1929 (Address) New Meadows, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meadows Valley Cemetery	Oct. 20, 1929
20. Undertaker	**Address**
I. O. O. F. Lodge	New Meadows

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67850

PLACE OF DEATH

County of Bannock

City of Downey

Registration District No. 83

Primary Registration District No. 2160

Local Registrar's No. 118

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Donald Webster Barfus 90

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 6 1906

7. AGE	Years	Months	Days	If LESS than 1 day,
	23	00	8	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Richmond Utah

PARENTS

10. NAME OF FATHER John A. Barfus

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minkcreek Idaho

12. MAIDEN NAME OF MOTHER Mary May Bowman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Richmond Utah

14. Informant John A. Barfus

(Address) Downey Idaho

15. Filed Oct-25-, 1929 Mary C. Coffin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October - 14 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May-27-, 1929 to Oct-14-, 1929
that I last saw him alive on Oct-14- 1929
and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease
(Patent Foramen Ovale)

Since birth (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

Oct 16 1929 (Signed) D. F. Partridge M. D.
(Address) Downey Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cambridge Cemetry	Oct 16 1929

20. Undertaker M. W. Hendricks Address Preston Idaho

FORM [illegible] No. 5-A—25 M. [illegible] NOV 14 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 67851

Registered No. 119

1. PLACE OF DEATH

County of Bannock

City of Downey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83

Primary Registration District No. 2160

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Corydon Yates Phillips

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Divorced (Write the word.)

6. DATE OF BIRTH: July (Month) 9th (Day) 1860 (Year)

7. AGE: 69 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Villisca Iowa.

10. NAME OF FATHER: Lemon T. Phillips

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Lucina Yates

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mason E Phillips

(Address) Daniel Wyo.

15. Filed Nov. 10 - 1929 Mary E. Coffin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) - 24 (Day) - 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct - 17 - 1929, to Oct - 24 - 1929 that I last saw him alive on Oct 24 1929 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Insanity

(Duration) One Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Hartigsen M. D.

Oct 24 1929 (Address) Downey Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 12 days. In the State ..... yrs. ..... mos. 12 days

Where was disease contracted if not at place of death?

Former or usual residence Daniel, Wyo.

19. PLACE OF BURIAL OR REMOVAL: Kemmerer Wyo. DATE OF ~~BURIAL~~ Removal 10-24 1929

20. UNDERTAKER: M. W. Hendricks ADDRESS Preston Id.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 27852

Local Registrar's No. 164

PLACE OF DEATH

County of Bannock

City of Bancroft

Registration District No. 84

Primary Registration District No. 2161

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Carlos G. Welch

(a) Residence. No. 101a St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept 15 29

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bancroft Ida

PARENTS

10 NAME OF FATHER Judson Welford Welch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Utah

12 MAIDEN NAME OF MOTHER Alice Pearl Tomlinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah

14 Informant Judson Welford Welch

(Address) Bancroft Ida

15 Filed Oct 9, 1929 Mrs G G Fox Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 9 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929, to Oct 9, 1929, that I last saw him alive on Oct 9, 1929, and that death occurred, on the date stated above, at 8:45A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, lower Left Lung

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Insufficient bile drainage from Gall bladder

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? examination

(Signed) G G Fox, M. D.

Oct 9, 1929 (Address) Bancroft Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Salt Lake City	
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67853

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2101
Local Registrar's No. 5679

(No. 128 North 14th, Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Lucious A. Peck

(a) Residence. No. Rockland, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Evelyn Roundy

6. DATE OF BIRTH (month, day and year) July 24, 1848.

7. AGE	Years	Months	Days	If LESS than 1 day,
	81	2	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wyoming

PARENTS

10. NAME OF FATHER Martin H. Peck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant George D. Peck
(Address) 128 N. 14th. Ave. Poca. Idaho.

15. Filed 10/18, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 16, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Oct 16, 1929
that I last saw him alive on Oct 15, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Senility
Uremia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Enlarged Prostate Suppressed
(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 1925
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) J. H. Young M. D.
Oct 17, 1929 (Address) Poca Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rockland, Idaho.	10/18/29.

20. Undertaker	Address
Arthur W. Hall	Pocatello

RECEIVED OCT 21 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67854

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2141
(No. Basement of 122 South First Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5678

2. FULL NAME Henry Washington

(a) Residence. No. 306 North Second Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

197

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Luevenia Foster

6. DATE OF BIRTH (month, day and year) June 3, 1904.

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	25	4	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas City, Kan.

PARENTS

10. NAME OF FATHER Finis Washington
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri.
12. MAIDEN NAME OF MOTHER Bessie Moss
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas.

14. Informant Mrs. Henry Washington
(Address) 306 N. Second Ave. Poca. Ida.

15. Filed 10/17, 1929. J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 11, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:
Gun shot Wound at the hand of John McShann (Homicidal)
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Arthur W. Hall Coroner M. D.
10/1, 19 29 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	10/20/29.

20. Undertaker Arthur W. Hall Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67855

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5677

(No. Lynn Brothers Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward David Reese

1612

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 15, 1929.

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	0	0	One hrs. or 30 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER E. M. Reese

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spanish Fork, Utah.

12. MAIDEN NAME OF MOTHER Emma Whitaker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Neeley, Idaho.

14. Informant Edward D. Reese
(Address) Pocatello, Idaho.

15. Filed 10/17, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 15, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Oct 15, 1929
that I last saw h[illegible] alive on Oct 15, 1929
and that death occurred, on the date stated above, at 6:30 P m.
The CAUSE OF DEATH* was as follows: Premature Birth

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of —
Was there an autopsy? no —
What test confirmed diagnosis? Examination
(Signed) J. H. Young, M. D.
Oct 16, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	10/16/29.
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67856

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5676
(No. Canal at 13th Ave. & Center St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dale William Decker

(a) Residence. No. 1420 East Center St. Poca. Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 1 8 2 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 5, 1927.

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	6	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer At Home

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Frank Z. Decker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Martha L. Hunter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oakley, Idaho.

14. Informant Frank Z. Decker
(Address) Pocatello, Idaho.

15. Filed 10/17, 1929. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 15, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Drowning fill in ditch
while playing with other children
(accidental)
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? ... Date of ...
Was there an autopsy? ...
What test confirmed diagnosis? ...
(Signed) Arthur W Hall Coroner M. D.
10/17, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	10/ 17/ 29
20. Undertaker Arthur W. Hall	Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67857

Registration District No. 28

Primary Registration District No. 2141

Local Registrar's No. 5675

(No. 639 N 5th)

(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH

County of Bannock

City of Pocatello

2. FULL NAME Sydney Smith 40

(a) Residence. (Usual place of abode) No. 639 N 5th St.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 25th 1925

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4	3	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Ida

PARENTS

10. NAME OF FATHER Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Pearl Washington

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Texas

14. Informant Mrs Pearl Hart

(Address) Pocatello Idaho

15. Filed 10/10, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 4th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4, 1929, to Oct 4, 1929 that I last saw him alive on Oct 4, 1929 and that death occurred, on the date stated above, at 4,20 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

3 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J. H. Young, M. D.

10-4, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	10-6 1929
20. Undertaker	Address
Schumacher & Brady	Pocatello

RECEIVED OCT 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67858

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 3674

(No. 1138 North Eighth Ave. Poca. Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jessie W. Larsen

(a) Residence. No. 1138 North Eighth Ave. St. 89
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Husband of Lillian Chandler

6. DATE OF BIRTH (month, day and year) Feb. 22, 1894.

7. AGE	Years	Months	Days	If LESS than 1 day,
	35	7	15	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Steel Car Man

(b) General nature of industry, business, or establishment in which employed (or employer) Car Dept.

(c) Name of employer O. S. L. R. R.

9. BIRTHPLACE (city or town) (State or country) Rexburg, Idaho.

PARENTS

10. NAME OF FATHER Birtle M. Larsen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway

12. MAIDEN NAME OF MOTHER Caroline Halverson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Mrs. Jessie W. Larsen
(Address) 1138 N. Eighth Ave. Poca. Ida.

15. Filed 10/9, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 7, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Oct 7, 1929
that I last saw h[illegible] alive on Oct 7, 1929
and that death occurred, on the date stated above, at 7 p m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature] M. D.
10-9, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg, Idaho.	10/11/29.

20. Undertaker Arthur V. Hall Address Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67859

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161

Local Registrar's No. 5673

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

140

2. FULL NAME Mrs. Paul Matouple

(a) Residence. No. Katharena St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Married - Paul Matouple

6. DATE OF BIRTH (month, day and year) May 30 1883

7. AGE Years 46 Months 4 Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) Romania

PARENTS
10. NAME OF FATHER Godthef Muster
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Romania
12. MAIDEN NAME OF MOTHER Dent Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant (Address) P. G. Matheopol, Pocatello

15. Filed 10/9, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/1/29, 1929, to 10/8, 1929
that I last saw her alive on 10/8, 1929
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:
Hemorrhage from —
Abdominal ascites —
Shock — Gall stones —
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chr. G.B. ascites — Loss blood
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? Yes Date of 10/7/29
Was there an autopsy? No
What test confirmed diagnosis? Usual signs
(Signed) H C Jowin, M. D.
10/8, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rhoades Valley Idaho Date of Burial Oct 13 1929

20. Undertaker E F Peck Address Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67860

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5672

(No. 936 South Main St. Poca. Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Davis

43

(a) Residence. No. 936 South Main St. Poca. Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
About	78			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant H. S. Buckley

(Address) Pocatello, Idaho.

15. Filed 10/7, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 2, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-15, 1929, to 10-2, 1929
that I last saw h alive on 10-2, 1929
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Esophagus

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Young M. D.

10/7, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	10/8/29. 19

20. Undertaker A. W. Hall Address Pocatello, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 21 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67861

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5671

(No. St Anthony Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Lou Arnold 154

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed or Divorced (write the word) Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 3-1926

7. AGE 3 Years | Months 4 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden Utah

PARENTS

10. NAME OF FATHER Leo Arnold

11. BIRTHPLACE OF FATHER (city or town) (State or Country) or Indiana

12. MAIDEN NAME OF MOTHER Edna Ludwig

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ogden Utah

14. Informant Mrs Edna Arnold

(Address) Pocatello Ida

15. Filed 10/6, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3, 1929, to Oct 5, 1929

that I last saw her alive on Oct 5, 1929

and that death occurred, on the date stated above, at 3 9 m.

The CAUSE OF DEATH* was as follows:

Peritonitis of Appendicitis Organ (Suppuration type)

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Suppuration appendicitis

(duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? St Anthony Hospital

Did an operation precede death? Yes Date of Oct 3/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. Hall, M. D.

Oct 6, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View | Date of Burial Oct 7 1929

20. Undertaker Schumacher Beasley | Address City

RECEIVED OCT 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67862

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St. Anthony Hospital. Poca. Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5670

2. FULL NAME Thaddeus Walker 162

(a) Residence. No. Pocatello, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 0 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 25, 1929.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Lorin L. Walker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Brigham City, Utah.
12. MAIDEN NAME OF MOTHER Vera Hendricks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oxford, Idaho.

14. Informant Lorin L. Walker
(Address) Inkom, Idaho.

15. Filed 10-3, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 2, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 1929
that I last saw h~~e~~ alive on Oct 2, 19...
and that death occurred, on the date stated above, at 11:30 a m.
The CAUSE OF DEATH* was as follows:
Atelectasis of Lungs

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) 6 hrs Premature birth
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. S. Miller M. D.
10-2, 1929 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Inkom, Idaho.	10/3/29/ 19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67863

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5669
(No. 807 N. 7th ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Elmer Pitts
(a) Residence No. 807 N. 7th ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

12 8

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Jan 17, 1922

7. AGE: 7 Years, 8 Months, 6 Days. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello Ida.

PARENTS
10. NAME OF FATHER: Chas T. Pitts
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Lilian Striker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho.

14. Informant: Lilian Aldrich
(Address): Pocatello, Idaho

15. Filed Oct 2, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 1, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-1, 1929, to 10-3, 1929
that I last saw him alive on 10-3, 1929
and that death occurred, on the date stated above, at 12 45 P. m.
The CAUSE OF DEATH* was as follows:
Nephritis - acute -
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Cervical adenitis -
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. Young M. D.
10/3, 1929 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Idaho — Date of Burial: Oct 4 1929

20. Undertaker: McHan Undt Co — Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67864

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 743 N 4th)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5667

2. FULL NAME Maria Magdalena Vasques

(a) Residence. No. 743 N 4th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Brown
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years 20 Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work [illegible]
(b) General nature of industry, business, or establishment in which employed (or employer) unemployed.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mexico

PARENTS
10. NAME OF FATHER Jose Vasques
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico
12. MAIDEN NAME OF MOTHER Josephina Ramirez
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico

14. Informant Mrs Jose Vasques
(Address) 743 N 4th

15. Filed 9-29, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21, 1929, to Sept 25, 1929
that I last saw her alive on Sept 21, 1929
and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Both Lungs
(duration) 1 yrs. 8 mos. — ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? physical findings
(Signed) J. H. Young M. D.
9-25, 1925 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt View
Date of Burial 10-1 1929

20. Undertaker Schumacher & Beasley
Address City

RECEIVED OCT 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67865

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 329 N. Hayes)
(If death occurred in a hospital or institution, give its name instead of street and number)

Local Registrar's No. 5666

2. FULL NAME Richard Henry Kreuzer 162

(a) Residence. No. 329 N. Hayes St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Baby

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 10-1929

7. AGE Years Months Days 3 If LESS than 1 day ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS
10. NAME OF FATHER Henry Kreuzer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Lena Greiner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant Henry Kreuzer
(Address) 329 N. Hayes

15. Filed 9-29, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1929, to Sept 10, 1929
that I last saw her alive on Sept 10, 1929
and that death occurred, on the date stated above, at ___ m.
The CAUSE OF DEATH* was as follows: Fromm Ovale Failed to Close
(duration) ___ yrs. ___ mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? Congenital
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Exam
(Signed) O. F. Leall, M. D.
9/16/29, 19__ (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View
Date of Burial Sept 14 1929

20. Undertaker Schumacher & Beasley
Address City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67866

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5665

(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lavina Jean Talbot

114

(a) Residence. No. 1546 North Main St. Poca. Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 26, 1926.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
3	0	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot, Idaho.

PARENTS

10. NAME OF FATHER E. R. Talbot

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Layton, Utah.

12. MAIDEN NAME OF MOTHER Minnie Waite

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dayton, Idaho.

14. Informant E. R. Talbot
(Address) 1546 North Main St. Poca. Idaho.

15. Filed 9-25, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 22, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21, 1929 to Sept 22, 1929
that I last saw her alive on Sept 22, 1929
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows: Diarrhea and enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Thaustion

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) William F. Howard M. D.

Sept 24, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Blackfoot, Idaho.

Date of Burial: 9/26/29 19

20. Undertaker: Arthur W. Hall

Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67867

PLACE OF DEATH
County of Bear Lake
City of Paris
Registration District No. 3-3
Primary Registration District No.
Local Registrar's No. 127
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Ann Lewis

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. ~~If married~~, widowed, or ~~divorced~~ ~~Husband~~ of (or) WIFE of Joseph Lewis

6. DATE OF BIRTH (month, day and year) May 8 1845

7. AGE: Years 84 | Months 5 | Days 12 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Fred Lewis
(Address) Paris Idaho

15. Filed 10-23 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
No Physician attending
Death from natural causes.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

10/23 (Signed) C O Moore M. D.
, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Paris Idaho	10-23 1929
20. Undertaker	Address
Edwin T. Shepherd	Paris Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 12 1929

PLACE OF DEATH

County of Benewah

City of St. Maries

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

DO NOT WRITE IN THIS SPACE

State File No. 67868

Local Registrar's No. 32

(No. 490)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Ryan

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Irish	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1872

7. AGE	Years	Months	Days	If LESS than 1 day,
	57			hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rancher & logger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N.Y.

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant CARL M. KRAEMER,

(Address) PLUMMER, IDAHO

15. Filed Nov 1st, 1929 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/27, 1929, to 10/29, 1929, that I last saw him alive on 10/28, 1929, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza, Chronic 10 days

Nephritis duration unknown
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C A Robins, M. D.

10/30, 1929 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Plummer, Ida	Oct. 31 1929

20. Undertaker	Address
[illegible]	Plummer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 12 1929

PLACE OF DEATH

County of Benewah

City of St. Maries

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

DO NOT WRITE IN THIS SPACE

State File No. 67869

Local Registrar's No. 31

(No. 90)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wm Eglesby

(a) Residence. No. ..... St. Clarkia Idea

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day,
	69			hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) ✓
(State or country)

PARENTS

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (city or town) ✓
(State or Country)

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (city or town) ✓
(State or Country)

14. Informant Ed Dennis

(Address) Clarkia Idaho

15. Filed Nov 1st, 1929 Walter Boberg
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/26, 1929, to 10-26, 1929

that I last saw him alive on 10/25, 1929

and that death occurred, on the date stated above, at 5.30a m.

The CAUSE OF DEATH* was as follows: Chronic aortic insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G Stapp, M. D.

10/26, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Maries	Oct 28 1929
20. Undertaker	Address
Geo B Mitchell	St Maries

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 12 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 67870

Registered No. 30

Registration District No. 32

Primary Registration District No. 2049

1. PLACE OF DEATH.

County of Benewah

City or St. Maries Ida (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Warren Benner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 12 (Day) 1858 (Year)

7. AGE: 71 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Henry Zimmerman

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Sharman

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Morasch

(Address) St. Maries, Ida

15. Filed Nov 1st 1929 Walter Boberg Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1929, to Oct 11 1929, that I last saw her alive on Oct 11 1929, and that death occured on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Unknown

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C A Robins M. D.

10/12 1929 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Not known

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries Ida — DATE OF BURIAL: Oct 13 1929

20. UNDERTAKER: Geo W Mitchell — ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BDRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67872

PLACE OF DEATH
County of Bingham
City of Springfield

Registration District No. 116
Primary Registration District No. 2195
Local Registrar's No. 3

(No.) 57
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter A Edwards

(a) Residence. No. — St. Springfield Ida
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Agusta C. Edwards

6. DATE OF BIRTH (month, day and year) June 18 1852

7. AGE Years 77 Months 4 Days 13 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Pararie Du Sac. Wis.

PARENTS

10. NAME OF FATHER Henry Elias Edwards

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Anna M Chrisenot Ohio Penn

12. MAIDEN NAME OF MOTHER Anna M. Chrisenot

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Augusta C Edwards
(Address) Springfield Idaho

15. Filed Nov 1, 1929 M. C. MacKinnon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1925, to , 19
that I last saw him alive on Oct 20, 1929
and that death occurred, on the date stated above, at 8:50 a.m.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory test of urine
(Signed) M. C. MacKinnon, M. D.
11-1, 1929 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grondeily Cemetery
Date of Burial Nov 3rd 1929

20. Undertaker E J Peck
Address Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 67873

PLACE OF DEATH

County of Bingham

City of Blackfoot

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 1007

(No. .....)

Local Registrar's No. 184

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Rachel Margarette Bingham

(a) Residence. No. 86 North University St. 109 B

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Married~~ Joseph F. Bingham

6 DATE OF BIRTH (month, day and year) Dec. 19 1902

7 AGE: Years 26 | Months 11 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Blackfoot, Idaho

PARENTS

10 NAME OF FATHER Thos. R. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) LeSeuer Minn.

12 MAIDEN NAME OF MOTHER Mary E. Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austin Minn.

14 Informant Fred H. Vogt

(Address) Blackfoot, Idaho.

15 Filed Nov. 1, 1929 Wm Walter E. Pierce Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October (Month) 30 (Day) 1929 (Year) 19

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1929, to Oct. 30/29, 19

that I last saw her alive on Oct 30 1929, 19

and that death occurred, on the date stated above, at 8. A.M. m.

The CAUSE OF DEATH* was as follows:

Streptoccic Infection

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Infected Tonsils

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. W. Mitchell, M. D.

10/30/29 19 (Address) Blackfoot. I

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Groundcity cemetery

Date of Burial: Nov. 2nd 1929

20. Undertaker: E J Peck

Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67874

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 183

(No. SOUTH IDAHO INSANE ASYLUM)

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Francis M. STRAIGHT

(a) Residence. No. ..... St. Blackfoot, Ida

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 4 yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE

4. COLOR OR RACE WHITE

5. Single, Married, Widowed, or Divorced (write the word) WIDOWER

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 66 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work FARMING

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ---

9. BIRTHPLACE (city or town) (State or country) Madison, Wis.

PARENTS

10. NAME OF FATHER Joshua Straight,

11. BIRTHPLACE OF FATHER (city or town) (State or Country) NY

12. MAIDEN NAME OF MOTHER ---

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) NY

14. Informant Grace A. Clippinger RN

(Address) Blackfoot, Ida.

15. Filed Oct 28, 1929 Mrs Walter Catine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 28th, 1929 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1927, 19..... to Oct 27 1929, 19.....

that I last saw him alive on Oct 26th 1929, 19.....

and that death occurred, on the date stated above, at 6:40A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Geo Williams, M. D.

Oct 28th, 1929, 19..... (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Asylum Cemetary — Date of Burial 10/29 1929

20. Undertaker Mr. Ely — Address Blackfoot

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67875

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 182

74a

2. FULL NAME PETER GRESSMAN

(a) Residence. No. ..... St. MONTPELIER IDAHO
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	87			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Common Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Texas

PARENTS

10. NAME OF FATHER ---

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ---

12. MAIDEN NAME OF MOTHER ---

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ---

14. Informant Grace A. Clippinger R.N.
(Address) Blackfoot, Ida.

15. Filed Oct 29, 1929 McCalvert Curtis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: OCTOBER (Month) 27th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18th 1929, 19..., to Oct 27th 1929, 19...
that I last saw him alive on Oct 27th 1929 19... 3:20P
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Age

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo. Williams, M. D.
Oct 28th 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Asylum Cemetary	10/29/ 1929
20. Undertaker: Mr. Ely	Address: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67876

PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 12
Primary Registration District No. 2194
Local Registrar's No. 181
(No.) 74A
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dora Kelly Stalker

(a) Residence. No. Shelley Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 3 1865

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	7	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah Springville

PARENTS

10. NAME OF FATHER Joseph Kelly
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lawrenceville Kentucky
12. MAIDEN NAME OF MOTHER Elizabeth Potter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Olive Stalker
(Address) Boise Idaho Ex State Treasurer

15. Filed Oct 31 19 29 McCallie Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ Oct 20, 19 29, to , 19 , that I last saw her alive on Oct 20, 19 29 and that death occurred, on the date stated above, at 12/10 A.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical findings

(Signed) J. O. Peterson M. D.
10-21 19 29 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Soda Springs Idaho	Oct 23 1929

20. Undertaker G. J. Peck — Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67877

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 180

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188 e

2. FULL NAME William T. Salverson

(a) Residence. No. Blackfoot. R. F. D. 3 St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence Salverson

6. DATE OF BIRTH (month, day and year): June, 12, 1882.

7. AGE: Years 47 | Months 4 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10. NAME OF FATHER: Thorvald Salverson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Anna Hansen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway.

14. Informant: Florence Salverson

(Address): Blackfoot. R. F. D. 3

15. Filed Oct 17, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 16. 1929. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 6;30 P. m.

The CAUSE OF DEATH* was as follows:

Automoble Accident caused fractur of skull, broken neck, and broken legs. Accidental.

Coroners Jury Verdict. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Doctors examination

(Signed) Ray McClellan, Coroner of Bingham County.

Address Oct. 17, 1929 Blackfoot. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Grove City Cemetary

Date of Burial: 10-20-29 19

20. Undertaker: Modern Mortuary

Address: Blackfoot,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67878

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 179

2. FULL NAME Bernice Edith Ballard 163

(a) Residence. No. Basalt Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Oct. 11 " 29

7. AGE Years Months Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Basalt Ida

PARENTS
10. NAME OF FATHER Wm Ballard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nampa Cal
12. MAIDEN NAME OF MOTHER Bessie James
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Susuan Cal.

14. Informant William Ballard
(Address) Basalt Idaho

15. Filed Oct 17, 1929 Mrs Walter E. Catmie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 16 " 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1929 to Oct 16, 1929
that I last saw her alive on Oct 14 " 1929
and that death occurred, on the date stated above, at 6.30 a m.
The CAUSE OF DEATH* was as follows:
Accidently Smothered by Mother
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) None
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) F. McNeil, M. D.
Oct 17, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Firth, Idaho — Date of Burial Oct 17 1929

20. Undertaker None — Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

PLACE OF DEATH

County of Bingham

City of Shelley

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67879

Registration District No. 121

Primary Registration District No. 2144

Local Registrar's No. 178

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bonnie Jewel Clifford

(a) Residence. No. Shelley, Idaho St. 162

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 7, 1929

7. AGE Years Months 5 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley, Idaho

PARENTS

10. NAME OF FATHER Brandon Clifford

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Grant, Idaho

12. MAIDEN NAME OF MOTHER Ellen Lindquist

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Umbler, Oregon

14. Informant Mrs Brandon Clifford

(Address) Shelley, Idaho

15. Filed Oct 17, 1929 Wm Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 15 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ about 11 30 on 10-16-1929 ~~to~~ ~~19~~

that I last saw her alive on 10-16-1929

and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

apparently was acute Toxic Endo-Carditis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Not certain

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Edwin Cutler M. D.

10-18-1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Shelley — Date of Burial Oct. 18 1929

20. Undertaker Jack A. Hood — Address Idaho Falls

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67880

PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2194.
Local Registrar's No. 177
(No. 162)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Van Orden

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 15, 1929

7. AGE Years	Months	Days	If LESS than 1 day,
			hrs. or 15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Blackfoot
(State or country) Idaho

PARENTS

10. NAME OF FATHER William J. Vandrden
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Hazel May Baker
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Utah

14. Informant Wm. J. Van Orden
(Address) Aft. P. Ida. R#2.

15. Filed Oct. 16, 1929 McWalter E. Cates Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929 to Oct 16, 1929
that I last saw him alive on Oct 15, 1929
and that death occurred, on the date stated above, at 7:45 P m.
The CAUSE OF DEATH* was as follows:

Cardiac Weakness
Congenital
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A W Beck, M. D.
10/16, 1929 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverside - Thomas Cem.	10-16-1929

20. Undertaker Modern Mortuary Address Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67881

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
Local Registrar's No. 176
(No. County Hospital W. Judicial St
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Cohen West
(a) Residence. No. County Hospital St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

134

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed & Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 13 1867

7. AGE Years 62 Months 2 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Trader & Junk Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft. Wis.

PARENTS
10. NAME OF FATHER George West
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Helen Virgil
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant W. E. Patrie
(Address) Blackfoot Idaho

15. Filed Oct 17, 1929 Wm Walter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929, to Oct 14, 1929
that I last saw him alive on Oct 14, 1929
and that death occurred, on the date stated above, at 6:30 P m.
The CAUSE OF DEATH* was as follows:
Progressive Spinal Paralysis
Non contagious
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Enlarged Prostate & Stricture of Urethra
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) W. E. Patrie, M. D.
Oct. 16, 1929 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Grove City Cemetery
Date of Burial Oct. 17 1929

20. Undertaker E. J. Funk
Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67882

PLACE OF DEATH
County of Bingahm
City of Blackfoot.

Registration District No. 121
Primary Registration District No. 1007
Local Registrar's No. 175

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME James Buttcane

(a) Residence. No. North Main St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Buttcane

6. DATE OF BIRTH (month, day and year) Mar. 30, 1851

7. AGE ~~68~~ 78 Years [illegible] Months 6 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Groceries
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER William Buttcane
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Eliza Lack
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Carrie Tanner
(Address) Blackfoot, Ida.

15. Filed Oct 14, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 12. 1929. 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12, 1929, to Oct 12, 1929.
that I last saw him alive was dead when I arrived
and that death occurred, on the date stated above, at 2:25 a m.
The CAUSE OF DEATH* was as follows:
Sudden Heart Failure
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Myocarditis
..... (duration) 4 or 5 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No (Cardiac region)
What test confirmed diagnosis? Had sudden pain in
(Signed) W W Beck, M. D.
Oct 12, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Blackfoot. Ida. Date of Burial 10-15-1929

20. Undertaker Modern Mortuary, Address Blackfoot. Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

PLACE OF DEATH

County of Bingham

City of Blackfoot

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67883

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 174

(No. 40 No Shelling Core)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Warren Spalding 88B

(a) Residence. No. 44 North Shelling St. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Louise E. Spalding

6. DATE OF BIRTH (month, day and year): June 11th 1843

7. AGE: Years 86, Months 3, Days 29. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Nashua New Hampshire

PARENTS

10. NAME OF FATHER: Salomon Spaulding

11. BIRTHPLACE OF FATHER (city or town) (State or Country): New Hampshire

12. MAIDEN NAME OF MOTHER: Sarah Darling

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New Hampshire

14. Informant: Louise E. Spalding

(Address): Blackfoot Idaho

15. Filed: Oct. 12, 1929 Mrs Evalus E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) – 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on 10 – 10, 1929, to ....., 19....

that I last saw him alive on 10 – 10, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis with myocarditis

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) J. O. Hampton, M. D.

10 – 11, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Gem City Cemetery — Date of Burial: Oct 13 1929

20. Undertaker: E T Peck — Address: Blackfoot

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67885

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
Local Registrar's No. 172

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William S. Rumble 57

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Edith Rumble

6. DATE OF BIRTH (month, day and year): Sep 13 1855

7. AGE: Years 74 | Months | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Watchman
(c) Name of employer: Utah Idaho Sugar Co

9. BIRTHPLACE (city or town) (State or country): Greensboro Penn

PARENTS
10. NAME OF FATHER: Jacob Rumble
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Elizabeth Haught
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn

14. Informant: Harry G Rumble
(Address) 850 No. 10th St Pocatello

15. Filed Oct 7, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 7th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to Oct 7th, 1929
that I last saw him alive on Oct 6th, 1929
and that death occurred, on the date stated above, at 6:45 A. m.
The CAUSE OF DEATH* was as follows: Diabetes Melites
..... (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical findings
(Signed) J. O. Hampton M. D.
10-7, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Groveland cemetery | Date of Burial: Oct 9 1929

20. Undertaker: E J Peck | Address: Blackfoot

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67886

PLACE OF DEATH
County of Bingham
City of Blackfoot.

Registration District No. 121.
Primary Registration District No. 2194.
Local Registrar's No. 171

(No. 119)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Helen Jane McBride

(a) Residence. No. Fort Hall, Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 11. 1928.

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	6	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fort Hall, Ida.

PARENTS

10. NAME OF FATHER A. W. McBride
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Martha Waite
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant A. W. McBride
(Address) Fort Hall, Ida,

15. Filed Oct 6, 1929 Mc Coulen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 5, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-3, 1929, to 10-5, 1929
that I last saw h alive on 10-4, 1929
and that death occurred, on the date stated above, at 4:10 A. m.
The CAUSE OF DEATH* was as follows:
acute Ileo-colitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no.
What test confirmed diagnosis? Physical findings

(Signed) J. O. Hampton M. D.
Oct. 5, 1929 (Address) Blackfoot. Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rockland Ida	10/7-1929
20. Undertaker	Address
Modern Mortuary	Blackfoot.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67887

PLACE OF DEATH
County of Bingahm
City of Blackfoot.

Registration District No. 121.
Primary Registration District No. 1007.
Local Registrar's No. 170

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louis Peter Larson

(a) Residence. No. East Bridge St. 129
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie M. Larson

6. DATE OF BIRTH (month, day and year): Oct. 18, 1863.

7. AGE: Years 65 | Months 11 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: State of Idaho

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS
10. NAME OF FATHER: Nels P. Larson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Mary A. Knutson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denamrk.

14. Informant: Carrie M. Larson
(Address) Blackfoot. Ida.

15. Filed Oct. 4, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 2. 1929. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1929, to Oct. 2, 1929
that I last saw him alive on Oct 2, 1929
and that death occurred, on the date stated above, at 8:10 P m.
The CAUSE OF DEATH* was as follows:

Nephritis

..... (duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Chemical
(Signed) F. W. Mitchell M. D.
10/3, 1929 (Address) Blackfoot. Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Grove City Cem. | Date of Burial: 10-5-29 19

20. Undertaker: Modern Mortuary, | Address: Blackfoot. Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67888

PLACE OF DEATH
County of Bingham
City of Shelley
Darrell

Registration District No. 121
Primary Registration District No. 2194
(No. Shelley)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 169

2. FULL NAME Darrell LeRoy Hagen
(a) Residence. No. Shelley Ida St. 162
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 10/1928.

7. AGE: Years 1 | Months | Days 14 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: no.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley Ida.

PARENTS
10. NAME OF FATHER Roy Hagen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn.
12. MAIDEN NAME OF MOTHER Mary Grace Cole
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn.

14. Informant Roy Hagen
(Address) Shelley Ida

15. Filed Oct 11, 1929 McClaters E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 25 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24, 1929, to Sept 25, 1929
that I last saw him alive on Sept 25 1929
and that death occurred, on the date stated above, at 1 P.M. m.
The CAUSE OF DEATH* was as follows:
Cholera Infantum
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) F. E. Rasmussen, M. D.
Sept 26, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Shelley Ida. | Date of Burial: Sept 26 1929

20. Undertaker: Cliff Hayes | Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67889

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 39

161a

2. FULL NAME Laurence Monroe Holmes

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) 10-16-29

7. AGE Years | Months | Days | If LESS than 1 day, 6 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hailey, Idaho

PARENTS
10. NAME OF FATHER A. J. Holmes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vernal Utah
12. MAIDEN NAME OF MOTHER Elizabeth Irons
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Garfield Kansas

14. Informant A. J. Holmes
(Address) Hailey Idaho

15. Filed 10-31, 1929 R. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-16, 1929 to 10-16, 1929
that I last saw him alive on 10-16, 1929
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows: Premature birth

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. W. H, M. D.
10/17, 1929 (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey Idaho
Date of Burial: Oct 11 1929

20. Undertaker: Harris & Amos
Address: Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67896

PLACE OF DEATH

County of Blaine

City of Hailey

Registration District No. 57

Primary Registration District No. 2022

Local Registrar's No. 38

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

119

2. FULL NAME Catherine Helen Tracy

(a) Residence. No. St. (Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day and year) July 14, 1853

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	3	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boston, Mass.

PARENTS

10. NAME OF FATHER Wm Tracy

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Jane McManus

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant J. J. Tracy

(Address) Hailey Idaho

15. Filed 10-31, 1929 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25, 1929, to 10-22, 1929

that I last saw her alive on 10-22, 1929

and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Intestinal volvulus.

(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert H. Wright - M. D.

10-22, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
shipped to Madison Wis.	
20. Undertaker Harris & Amos	Address Hailey - Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67891

PLACE OF DEATH
County of Blaine
City of Ketchum

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 37

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fritz Reitzgen 49

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) X

7. AGE — Years: 72 | Months: X | Days: X | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rooming House
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10. NAME OF FATHER X
11. BIRTHPLACE OF FATHER (city or town) (State or Country) X
12. MAIDEN NAME OF MOTHER X
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant C. L. Ransom
(Address) Ketchum

15. Filed 10-31, 1929 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19..., to ✓, 19...
that I last saw h... alive on ✓, 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Found dead - evidently Angina Pectoris -
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Robert H. Wright, M. D.
10-19, 1929 (Address) Blaine Co. Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ketchum Idaho	Oct 28 1929
20. Undertaker: Harris & Tanner	Address: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67892

PLACE OF DEATH
County of Blaine
City of Ketchum

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 36

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME J. Ames

(a) Residence, No. Shoshone Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

119

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE: 82 Years Approx Months Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Hide Buyer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: A W Hansen
(Address) Shoshone Ida

15. Filed 10-31, 1929 R. H. Wright — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3rd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3rd, 1929, to Oct 4th, 1929
that I last saw him alive on Oct 4th, 1929
and that death occurred, on the date stated above, at 12 a.m.
The CAUSE OF DEATH* was as follows:
Gastro Enterites,

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Robert H. Wright M. D.
10-6, 1929 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone Idaho — Date of Burial: Oct 6 1929

20. Undertaker: C E Hickok — Address: Shoshone Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67893

PLACE OF DEATH
County of Blaine
City of Carey

Registration District No. 57
Primary Registration District No. 2045
Local Registrar's No. 35

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Earnest A. Gile

(a) Residence. No. ..... St. ..... 111a Fox
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of May Gile

6. DATE OF BIRTH (month, day and year) Jun 28 - 1858

7. AGE Years 71 Months 8 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Ray Ivie
(Address) Carey - Ida.

15. Filed 10-31, 1929 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1929, to Oct 2nd, 1929
that I last saw him alive on Oct 2, 1929
and that death occurred, on the date stated above, at 3.30 a m.
The CAUSE OF DEATH* was as follows: Gastric hemorrhage from perforating ulcer of stomach
..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? clinical
(Signed) E W Fox, M. D.
Oct 2, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Carey, Idaho — Date of Burial Oct 4 1929

20. Undertaker Harris Hamos E244 — Address Hailey - Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67894

County of Blaine
City of Ketchum
Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 34

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Owen Hampton

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Color
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): 1864

7. AGE: Years 65 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Postmaster
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Salt Lake City, Utah

PARENTS

10. NAME OF FATHER: John Hampton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Miss King
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. J. W. Riley
(Address) Ketchum, Idaho.

15. Filed 10-31, 1929 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 1st (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25, 1929, to Oct 1, 1929
that I last saw h[illegible] alive on Oct 1, 1929
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:
Acute myocarditis
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Mitral stenosis & lungs
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. W. [illegible], M. D.
Oct 2, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ketchum, Ida — Date of Burial: Oct 3 1929
20. Undertaker: Harris & Amos E.244 — Address: Hailey Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67895

Local Registrar's No. 79

PLACE OF DEATH

County of Boise

City of Placerville

Registration District No. 8

Primary Registration District No. 2004

(No. 1014)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minnie May Kennaly.

(a) Residence. No. ..... St. .....

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis E. Kennaly

6. DATE OF BIRTH (month, day and year) July 8-1885

7. AGE	Years	Months	Days	If LESS than 1 day,
	44	3	10	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Placerville Idaho

PARENTS

10. NAME OF FATHER W. H. Hiatt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Lizzie Ranft

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant Lewis E. Kennaly

(Address) Placerville Idaho

15. Filed 10-21 1929 W. H. Rhodes Registrar K.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 18th Fri. 1929

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 6th, 1929, to Oct. 18, 1929.

that I last saw h[illegible] alive on Oct. 18, 1929

and that death occurred, on the date stated above, at 6 30A m.

The CAUSE OF DEATH* was as follows:

~~Pneumonia~~

Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism.

(duration) yrs. mos. 1/2 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Earl Hill M. D.

Oct 19 1929 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Placerville Idaho	Oct 22 1929
20. Undertaker	Address
Summers & Krebs	Boise Ida

DISINTERMENT PERMIT

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Mrs. Minnie May Kennaly

now lying buried in Placerville Cemetery, in the City or Town of Placerville

County of Boise State of Idaho, who died on the 18 day of October, 1929 Aged 44 years 3 months

16 days, the cause of death being Lobar pneumonia and not directly or indirectly by diphtheria;(membranous croup);scariet fever;smallpox;leprosy;asiatic cholera;typhus fever; or yellow fever as shown by the certificate of death of said deceased, given by

Dr. Carl Hill attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private conveyance
private or railway conveyance

to Morris Hill Cemetery in the City or Town of Boise County of Ada

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Ada it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the Department of Public Health governing the Transportation of Corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the Department of Public Health at Boise, Idaho,

permit issued to:

this ____ day of July, A.D. 1953.

W L Benson
Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of Ada State of Idaho, this 20 day of July 1953.

Tennell D. Carr, M.D.
Health officer

Form DPH-48019

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67897

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME James H Barge

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 26 1868 Sandpoint

7. AGE	Years	Months	Days	If LESS than 1 day,
	61	4	27	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant W J French
(Address) Sandpoint Idaho

15. Filed Oct 24 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1928, 19..., to Oct-23, 1929
that I last saw h[im] alive on Oct-23, 1929
and that death occurred, on the date stated above, at 2 p.m.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart disease, Chronic Interstitial Nephritis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical

(Signed) Floyd G Wendle M. D.
Oct-24, 1929 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Oct 25 1929
20. Undertaker	Address
Turnbull Company	Sandpoint

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67898

PLACE OF DEATH
County of BONNER
City of SANDPOINT

Registration District No. 78
Primary Registration District No. 2155
(No. .....)
Local Registrar's No. .....
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Murray Molyneux 90

(a) Residence. No. 410 S. First Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Molyneux

6. DATE OF BIRTH (month, day and year) January 24, 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	8	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sullivan County Pa.

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Ellen Blake

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant Russel Molyneux
(Address) Sandpoint, Idaho.

15. Filed Oct. 25, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Oct 23, 1929, that I last saw ~~him~~ alive on Oct 22, 1929, and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:
Arteris-Sclerosis - Ascending gangrene starting in right foot.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. P. Stackhouse, M. D.
Oct. 24, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane, Washington.	Oct. 25 1929

20. Undertaker MOON MORTUARY Address SANDPOINT, IDA

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929

PLACE OF DEATH

County of Bonner

City of Sandpoint

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78

Primary Registration District No. 2155

(No. Page Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67899

Local Registrar's No.

1480

2. FULL NAME Charles Wood

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work woodsman

(b) General nature of industry, business, or establishment in which employed (or employer) Kunkesan Cedar Co

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unobtainable

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Page Hospital

(Address) Sandpoint

15. Filed Oct 22, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Oct 20, 1929

that I last saw him alive on Oct 15, 1929

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction.
Stasis due to shock.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Compound fracture tibia & fibula - leg struck by pole or small log while working in timber

(duration) ..... yrs. 5 mos. 5 ds.

18. Where was disease contracted if not at place of death? -

Did an operation precede death? No. Date of .....

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy

(Signed) O F Page, M. D.

Oct 21, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Oct 22 1929
20. ~~Undertaker~~ Funeral Co	Address Sandpoint

RECEIVED APR 7 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67899

Dr. O.F. Page
Sandpoint, Idaho
Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Charles Wood who died at Sandpoint, Idaho on Oct. 20, 1929. Stasis
Cause of death give as "Intestinal obstruction. stasis due to shock."
Contributory given as "Compound fracture tibia and fibula"
Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF DUE TO AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Leg was struck by a pole or small log while working in Timber. Had no contusion of abdomen or thorax

O F Page M.D.
Sandpoint Ida
April 9 - 30.

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67900

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

1. FULL NAME James O'Mara

(a) Residence. No. St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE: Years 65 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Parnell Hospital
(Address) Sandpoint Idaho.

15. Filed Oct 15, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 12th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28, 1929, to Oct. 12, 1929
that I last saw him alive on Oct. 11, 1929
and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease. Arterio sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirm[illegible]nosis?

(Signed) [illegible] M. D.
Oct. 15, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pinecrest Cemetery. Date of Burial: Oct. 15, 1929
20. Undertaker: R. E. Wenal Address: Priest River, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67901

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. Sandpoint, Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Nellie May Colpaert

(a) Residence. No. Sandpoint Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

5-8a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Hector Colpaert

6. DATE OF BIRTH (month, day and year): Apr. 30, 1895

7. AGE: 34 Years | Months: 5 | Days: 18 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Alpina Mich.

PARENTS

10. NAME OF FATHER: George Dunford
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Alpina Mich
12. MAIDEN NAME OF MOTHER: Grace Cochrane
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New Richmond Canada

14. Informant: Mr. Hoagland
(Address): Sandpoint Idaho

15. Filed Oct 19, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 17, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1929, to Oct. 17, 1929
that I last saw her alive on 16th of Oct, 1929
and that death occurred, on the date stated above, at 4 A. m.
The CAUSE OF DEATH* was as follows: Pernicious Anaemia
(duration) 1 yrs. 6 mos. ds.
CONTRIBUTORY (Secondary): Cholecystitis
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) Wm F. Tyler, M. D.
Oct 18, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pinecrest Cemetery | Date of Burial: Oct. 19, 1929

20. Undertaker: L. G. Moon | Address: Sandpoint Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 17909

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No. 709 N Third)
(If death occurred in a hospital or institution, give its name instead of street and number.)

#1

2. FULL NAME Oscar Sundeen

(a) Residence. No. 709 N Third St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 27 1888

7. AGE	Years	Months	Days	If LESS than 1 day,
	41	2	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work meat cutter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Gustave Sundeen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Christine Westberg.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Miss Beatrice Sundeen
(Address) Sandpoint Ida

15. Filed Oct. 17, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 14, 1929, to Oct 15th, 1929, that I last saw him alive on Oct 15th, 1929, and that death occurred, on the date stated above, at 8:05 P m.

The CAUSE OF DEATH* was as follows:
Acute Purulent (streptococcic - not meningococcic meningitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pyaemia, with involvement of both elbows and empyaema (duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no.
What test confirmed diagnosis? Laboratory & clinical

(Signed) John E. Bird, M. D.
Oct 16th, 1929 (Address) Spokane, Washington

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	10/18 1929
20. Undertaker Timmens Co	Address Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67903

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 16

Primary Registration District No. 2155

Local Registrar's No.

(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ralph Yaw

(a) Residence. No. 90 St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): July 27 (?)

7. AGE: Years 23 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: lumber
(b) General nature of industry, business, or establishment in which employed (or employer): worker
(c) Name of employer: Humbird

9. BIRTHPLACE (city or town) (State or country): Wash

PARENTS

10. NAME OF FATHER: Geo W Yaw

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Jennie Luther

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pa.

14. Informant: Geo W Yaw
(Address) Sandpoint Idaho

15. Filed Oct. 15, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8. 1929, to Oct 13 1929
that I last saw h~~im~~ alive on Oct. 12, 1929
and that death occurred, on the date stated above, at 5:20A m.

The ~~CAUSE~~ OF DEATH* was as follows:
Embolism heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation acute appendicitis

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Oct 10-29

Was there an autopsy? No.

What test confirmed diagnosis? Observed

(Signed) O F Bayer, M. D.

Oct 14, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery — Date of Burial: Oct 15 1929

20. Undertaker: Funeral Co — Address: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67904

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Baxter

44

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 64 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: lumber

(b) General nature of industry, business, or establishment in which employed (or employer): worker

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Page Hospital
(Address) Sandpoint.

15. Filed Oct 14, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1929, to Oct 12, 1929 that I last saw him alive on Oct 12, 1929 and that death occurred, on the date stated above, at 10:40 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of stomach

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Sept. 25-29

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) O F Page, M. D.

Oct 13, 1929 (Address) Sandpoint.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Portersville Calif | Date of Burial 19

20. ~~Undertaker~~ Turnbull Co | Address Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67905

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Laneda Twarr
(a) Residence. No. Sandpoint (Rural) St. 160
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept 28 1929
7. AGE Years Months Days 14 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Carl Twarr
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa
12. MAIDEN NAME OF MOTHER Alma Lee
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn

14. Informant Carl Twarr
(Address) Sandpoint, R I

15. Filed Oct 14, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 12 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 11, 1929, to Oct 12, 1929
that I last saw her alive on Oct 11, 1929
and that death occurred, on the date stated above, at 2:15 p.m.
The CAUSE OF DEATH* was as follows:
Icterus Neonatorum.
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? Clinical
(Signed) R. S. Ross M. D.
Oct 14, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Selle
Date of Burial Oct 14 1929
20. Undertaker Truwell Co
Address Sandpoint

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67906

PLACE OF DEATH
County of Bonner
City of Kootenai

Registration District No. 16
Primary Registration District No. 2155
(No. Kootenai)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME George La Lone

(a) Residence. No. Kootenai St. 48A
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 6 1855

7. AGE: Years 74 | Months 2 | Days 24 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: lumber worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS

10. NAME OF FATHER: George La Lone
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Michigan
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Michigan

14. Informant: Mrs Ella LaLone
(Address) Kootenai

15. Filed Oct 3, 1929 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) I (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1929, to Oct. 1, 1929
that I last saw him alive on Sept. 30, 1929
and that death occurred, on the date stated above, at 4:30A m.

The CAUSE OF DEATH* was as follows:
Chronic Endocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Wm F. Tyler, M. D.
Oct 2, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Oct 3 1929
20. Undertaker: Tumbull Co	Address: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67907

PLACE OF DEATH
County of Bonner
City of Newport

Registration District No. 83
Primary Registration District No. 2185
(No. .....)

Local Registrar's No. 31

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Louisa Anderson

(a) Residence. No. Larsen Ranch 3Mi. S. E. Newport St, Wn. 36
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb. 26, 1857

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72	7	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10 NAME OF FATHER: Bengt Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Christine Benson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: Mrs Hilda Larsen
(Address): Newport, Wash.

15 Filed Oct 21, 1929 A. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 19 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1925, to Oct. 19, 1929, that I last saw her alive on Oct. 18, 1929, and that death occurred, on the date stated above, at 6:00 a. m.

The CAUSE OF DEATH* was as follows:
Chronic Tuberculosis of left Kidney
(duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Not known
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Newport, Washington
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy findings

(Signed) A. D. Schlotthauer M. D.
Oct. 19, 1929 (Address) Newport, Wash.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Newport, Wash.	Oct. 22, 1929
20. Undertaker: Booth & Sherman	Address: Newport, Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67908

Registration District No. 7
Primary Registration District No. 1016
Local Registrar's No. 118

PLACE OF DEATH
County of Canyon
City of Nampa
(No. 403 Maple St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel W. Irwin

(a) Residence. No. 403 Maple St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

1016

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Jane Irwin

6. DATE OF BIRTH (month, day and year) January 1st, 185[illegible]

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	9	30	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Joseph Irwin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER Adline Dorcey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Mrs. Jane Irwin
(Address) Nampa, Idaho

15. Filed 11-1, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 31st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24, 1929, to Oct 31, 1929
that I last saw h[illegible] alive on Oct 31, 1929
and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No

(Signed) W C Wells M. D.
11/1, 1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rohlerlawn-Nampa	11-3 1929
20. Undertaker	Address
Wm D. Talley	Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 12 1929

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67909

Registration District No. 7

Primary Registration District No. 2006

Local Registrar's No. 117

(No. 3½ mi. south Nampa)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Neva June Ward

(a) Residence. No. 3½ mi. south Nampa St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

162

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 30th 1928

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	9	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Ralph R. Ward

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Laura Mendenhall

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant Mrs. Ralph R. Ward

(Address) Nampa, Idaho

15. Filed 10-27, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 26th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24, 1929, to Oct 26, 1929

that I last saw her alive on Oct 26, 1929

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows: Membranous Croup

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopy

(Signed) V C Beelman M. D.

11-1, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa

Date of Burial: 10-27 1929

20. Undertaker: Mrs. Nina M. Talley

Address: Nampa, Ida

RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67910

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 16
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eliza Jane Smart

(a) Residence. No. 414 Sugar Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of A. J. Smart

6. DATE OF BIRTH (month, day and year) July 23rd 1871

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
58	2	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Grocery Store
(c) Name of employer Morton

9. BIRTHPLACE (city or town) (State or country) Erie Kansas

PARENTS

10. NAME OF FATHER William Rhodes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Nancy Jane Price
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Mrs. Edgar Rosenhof
(Address) Nampa Idaho

15. Filed 10/31, 1929 Ruth Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 15th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to ____, 19__
that I last saw h__ alive on ____, 19__
and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:
Edema-Carcinoma with Ovarian Complications also Pneumonia Hypostatic
Terminal condition
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Smart arteriosclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? Yes Date of Oct 14
Was there an autopsy? No
What test confirmed diagnosis? ____
(Signed) [illegible] M. D.
10-31, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa — Date of Burial: 10/17 1929
20. Undertaker: Mrs. Nina M. Talley — Address: Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67911

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hospt)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 165

48 B

2. FULL NAME Bella Randall

(a) Residence. No. Nampa St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem.	White	Widow

5a. If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND of~~
~~(or) WIFE~~ of Frank A Randall

6. DATE OF BIRTH (month, day and year) Oct-12-

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Nellie B. Hartley
(Address) 223 Owen ave.

15. Filed Oct 18, 1929 Caldwell Idaho
Registrar
Bertha Conway

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 16, 1929
that I last saw h~~er~~ alive on Oct 16 1929
and that death occurred, on the date stated above, at 130 m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical signs

(Signed) H. P. Rose M. D.
Oct 18, 1929 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlenlawn Cem.	10/19/1929
20. Undertaker	**Address**
Fred K. Robinson	Nampa Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67912

Registration District No. 7
Primary Registration District No. 1506
Local Registrar's No. 14

PLACE OF DEATH
County of Canyon
City of Nampa
(No. 710)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Asa Lee Hackney

(a) Residence. No. 703 - 7th Ave N St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 14 - 1884

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	9	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Fur Buyer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Va

PARENTS

10. NAME OF FATHER Floyd Hackney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va
12. MAIDEN NAME OF MOTHER Lou Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Va

14. Informant A. L. Hackney
(Address) Burns, Oregon

15. Filed Oct 30, 1929 Hector Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 - 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-26, 1929, to 10-29, 1929
that I last saw h-im alive on 10-29, 1929
and that death occurred, on the date stated above, at 1:45 p. m.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed ~~diagnosis~~? Exam of Spinal fluid

(Signed) J. C. Barton, M. D.
10-30, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Ida	10-30 1929
20. Undertaker F. K. Robinson	Address Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67913

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 1 3
(No. Samaritan Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alford DeRoy Chester

(a) Residence. No. Rout #1. St. 2 miles 74R
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 5 - 1867

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	62.	—	37	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER James Chester
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER May.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Mr. M. A. Hatfield
(Address) Nampa, Idaho

15. Filed 10-14, 1929 Esther Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1929, to Oct 12, 1929
that I last saw him alive on Oct 12, 1929
and that death occurred, on the date stated above, at 10:40 P. m.
The CAUSE OF DEATH was as follows:

Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18. Where was disease contracted if not at ~~place of death~~?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. DeRoy Chester, M. D.
Oct 14, 1929 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian, Idaho	10-14 1929
20. Undertaker	Address
Wm. R. Talley	Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. RECEIVED NOV 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 2006

(No. ..... , ... St.)

File No. 67914

Registered No. 112

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Lafon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 20 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: H C Lafon

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Alice Knapp

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. W. Poynter

(Address) Nampa

15. Filed Oct 18 1929 Bertha Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1929, to Oct 16 1929 that I last saw her alive on Oct 16 1929 and that death occurred on the date stated above, at 12.40 M. The CAUSE OF DEATH was as follows:

Abscess of Right lung

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. W. Poynter M. D.

..... 19 ..... (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 9 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Murray Idaho

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19 .....

20. UNDERTAKER: F. R. Robinson | ADDRESS: Nampa Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67916

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 110

(No. Mercy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Cornell

(a) Residence. No. Montour Ida St. 124

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) ✓

7. AGE: 65 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ✓

PARENTS

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant E. A. Rober

(Address) Royston Hot Spgs. Ida

15. Filed 10-28, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19..., to ✓, 19...

that I last saw h..... alive on ....., 19...

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Wine exam

(Signed) Samuel A. Swayne M. D.

Oct. 28, 1929 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Catholic Cem

Date of Burial: 10-29 1929

20. Undertaker: J. K. Robinson

Address: Nampa Ida

RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67917

PLACE OF DEATH
County of Canyon
~~City of~~ Rural

Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 109
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert R Woodring 90
(a) Residence. No. Madison ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 23-1838

7. AGE Years 91 Months 5 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Undertaker
(b) General nature of industry, business, or establishment in which employed (or employer) (Retired)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS
10. NAME OF FATHER Nicholas Woodring
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Julia Anne Sifole
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant J. E. Woodring
(Address) Nampa Idaho

15. Filed Oct 10, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9, 1929, to Oct 9, 1929
that I last saw him alive on Oct 9, 1929
and that death occurred, on the date stated above, at 6 a.m.
The CAUSE OF DEATH* was as follows: Arterio sclerosis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Geo. R. Proctor, M. D.
12-7-1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Carroll Iowa
Date of Burial: 19

20. Undertaker: Fred K. Robinson
Address: Nampa Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67918

PLACE OF DEATH
County of Canyon
City of Rural

Registration District No. 7
Primary Registration District No. 2006

Local Registrar's No. 108

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna Marie Hansen 90

(a) Residence. No. 7 Miles West & North
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem.	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of M. P. Hansen

6. DATE OF BIRTH (month, day and year) June 1 - 1870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	4	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Jens. Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant M. P. Hansen
(Address) Caldwell Rt #1

15. Filed Oct 17, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1928, to Oct 13, 1929, that I last saw her alive on Oct 12, 1929 and that death occurred, on the date stated above, at 1 am m.

The CAUSE OF DEATH* was as follows:
Acute dilatation heart.
Arteriosclerosis & Organic heart.
(duration) 3 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & organic heart. (duration) 2+ yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Horace Bethmar, M. D.
10-13, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Ida	10-16 1929
20. Undertaker F. K. Robuin	Address Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

B

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67919

Local Registrar's No. 107

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

(No. 420 - 16th ave. So.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Viola Magill 49

(a) Residence. No. 420 - 16th ave. So. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: H. B. Magill

6. DATE OF BIRTH (month, day and year): May 15th 1866

7. AGE — Years: 63 — Months: 5 — Days: 1 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: house - wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS

10. NAME OF FATHER: Harris

11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Mrs. H. B. Magill

(Address): Nampa Idaho

15. Filed Oct 19, 1929 Estha Conner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ Stranger to ....., 19.....

that I last saw h... alive on ....., 19.....

and that death occurred, on the date stated above, at 1:15 A. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

..... (duration) 4 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Horace B Beckwith, M. D.

Oct 16, 1929 (Address) Nampa.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello, Idaho.	10-21 1929

20. Undertaker	Address
Mrs. Nina M. Talley.	Nampa, Ida

RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 87920

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 706
Local Registrar's No. 106
(No. Samaritan Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Evelyn May Lawson 90

(a) Residence. No. / St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a. If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ G W Lawson

6. DATE OF BIRTH (month, day and year) 2-5-1865

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
64	8	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kubec N.C.

PARENTS

10. NAME OF FATHER L. A. Dakin
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Boston

14. Informant G. W. Lawson
(Address) Nampa Ida

15. Filed 10-15, 1929 Bertha Conner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24, 1929, to Oct 12, 1929
that I last saw her alive on Oct 12, 1929
and that death occurred, on the date stated above, at 5:00 P m.
The ~~CAUSE OF DEATH~~* was as follows:
Mitral Stenosis
with secondary Nephritis.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) W C Hole, M. D.
Oct 12, 1929 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn	10-15 1929
20. Undertaker	**Address**
F H Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED NOV 13 1929

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67921

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 112

(No. 3 Miles Southwest of Bowmont Station
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Henry Ritchie

(a) Residence. No. 613 South 16th Boise St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Luella Ritchie.

6. DATE OF BIRTH (month, day and year): April 10th 1882

7. AGE: Years 47, Months 6, Days 5. If LESS than 1 day, ---------- hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Hoseman, Fire Dept.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Idaho City, Idaho.

PARENTS

10. NAME OF FATHER: John Ritchie.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Cecelia Burwash.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada.

14. Informant: Mrs. H. Ritchie.
(Address): Boise, Idaho.

15. Filed 10-19-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 15th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chromic Myocarditis. (Advice of his physician Dr H W Stone.)
Mr Ritchie fell dead while out hunting with Mr C. H. Yearington of Boise Ida.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): No inquest.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Paul L. Cash M. D.
Coroner
(Address) Caldwell, Ida.

October 18-29 19

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cenetery.
Date of Burial: 10/20/29 19

20. Undertaker: Wm. McBratney.
Address: Boise, Ida

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67922

PLACE OF DEATH

County of Canyon
City of Crofino

Registration District No. 90
Primary Registration District No. 2187

Local Registrar's No. 102

(No.) 117
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Baker Kinne

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Isabelle M. Kinne

6. DATE OF BIRTH (month, day and year) March 22 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	6	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant & Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer) Crofino Mercantile Co - White Pine Lumber Co.

(c) Name of employer Himself

9. BIRTHPLACE (city or town) Point Wolf
(State or country) New Brunswick, Canada

PARENTS

10. NAME OF FATHER John Kinne

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) St Johns New Brunswick. Canada

12. MAIDEN NAME OF MOTHER Mary Dunham

13. BIRTHPLACE OF MOTHER (city or town) St John
(State or Country) New Brunswick, Canada

14. Informant Helen Kinne McCarthy
(Address) Crofino Idaho

15. Filed Oct 2, 1929 W. A. Chase
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1929, to Oct. 1, 1929
that I last saw h— alive on Oct. 1, 1929
and that death occurred, on the date stated above, at 7:15 P. m.
The CAUSE OF DEATH* was as follows:

Acute appendicitis

(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Septicemia, streptococcic
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Sept. 29
Was there an autopsy? No
What test confirmed diagnosis? Operation.
(Signed) R. J. Hopkins M. D.
Oct 2, 1929 (Address) Crofino, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	Oct 3 1929

20. Undertaker	Address
W. A. Chase	Crofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 22 1929

PLACE OF DEATH

County of .....

City of .....

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 9

Primary Registration District No. 2007

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67923

Local Registrar's No. 9

2. FULL NAME Merle Wayne

(a) Residence. No. Parma, Ida - RFD 1 St. 167

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
—	—	—	5	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Parma Ida

PARENTS

10. NAME OF FATHER Wilbur T. Hamilton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lewis Co. Mo

12. MAIDEN NAME OF MOTHER Anna Dolores Smith

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Linn Co. Mo

14. Informant Mrs Anna Hamilton

(Address) Parma, Ida

15. Filed Nov 1, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1929, to Oct. 16, 1929

that I last saw h[illegible] alive on Oct. 16, 1929

and that death occurred, on the date stated above, at 1-30 a m.

The CAUSE OF DEATH* was as follows: Acute indigestion

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Colitis

(duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. W. Mulkey, M. D.

Oct. 18, 1929 (Address) Parma, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rosedale Cemetery	Oct. 16 1929
20. Undertaker	Address
None	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED NOV 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67924

PLACE OF DEATH

County of Canyon

City of Wilder

Registration District No. 3

Primary Registration District No. 2007

Local Registrar's No. 7

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stella Irene Simpson

(a) Residence. No. Wilder R#2 St. 31
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of W. J. Simpson.

6. DATE OF BIRTH (month, day and year) Dec-30-1878

7. AGE: 50 Years | Months: 9 | Days: 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: James Bourns

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wisc

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wisc

14. Informant W. J. Simpson
(Address) Wilder Ida

15. Filed Oct 10, 1929 Lulu Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct-1-29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from about Nov, 1927, to Oct 1, 1929
that I last saw her alive on Oct. 1, 1929
and that death occurred, on the date stated above, at 4:30 a.m.
The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

about
(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) W. E. Waldrop M. D.

Oct. 4, 1929 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker C. V. Peckham | Address Caldwell Ida.

RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67925

PLACE OF DEATH

County of Canyon
City of Wilder

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 122

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Henry Brown

(a) Residence. No. Wilder R# St. 44
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 5 1850

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	7	0	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Cutler Illinois
(State or country)

PARENTS

10. NAME OF FATHER Andrew Brown
11. BIRTHPLACE OF FATHER (city or town) Cutler Illinois
(State or Country)
12. MAIDEN NAME OF MOTHER Margarit Brown
13. BIRTHPLACE OF MOTHER (city or town) Illinois
(State or Country)

14. Informant Anna McCaw
(Address) Wieder Idaho

15. Filed 11-7- 1929 John L. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Nov 4, 1929 that I last saw him alive on Nov 4, 1929 and that death occurred, on the date stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver

(duration) ..... yrs. 11 mos. 24 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? NO Date of .....
Was there an autopsy? ✓
What test confirmed diagnosis? Nerve

(Signed) Robert E Talbot M. D.
Nov 5, 1929 (Address) Wilder

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cutler Illinois	19
20. Undertaker	Address
V. Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67926

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 121

2. FULL NAME Louvenia Coffee

(a) Residence. No. Golden Gate Dist, Caldwell St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 12, 1858

7. AGE	Years	Months	Days	If LESS than 1 day,
	71	1	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Heywood N Carolina

PARENTS

10. NAME OF FATHER Alfred B Patten

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Heywood, N C

12. MAIDEN NAME OF MOTHER Bashie Madaras

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Heywood, NC

14. Informant Mrs A R Colvard
(Address) Caldwell, Idaho

15. Filed 11-6-, 1929 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November 4 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1929, to Nov 4, 1929
that I last saw h[illegible] alive on Nov 3, 1929
and that death occurred, on the date stated above, at 3 P, m.
The CAUSE OF DEATH* was as follows:
General Paralysis of the insane
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J S Frame, M. D.
Nov 5, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Nov 6, 1929
20. Undertaker	Address
Paul L Case	Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67927

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 120

(No. 1010)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Dunn.

(a) Residence. No. 1007 Home St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 15-1853.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	~~20~~	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Novia Scotia

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs V H Price
(Address) Caldwell, Idaho.

15. Filed 11-4-, 1929. John L. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 2, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov, 1928, to Nov 2, 1929
that I last saw h~~e~~ alive on Nov 2, 1929
and that death occurred, on the date stated above, at 10 30 m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Senile Dementia
(duration) 1½ yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) J. M. Black, M. D.
11/4, 1929 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Nov 4 1929
20. Undertaker	**Address**
Paul L Case	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 13 1929

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67928

Registration District No. 3

Primary Registration District No. 1005

Local Registrar's No. 119

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arthur M. Steward

(a) Residence. No. ~~622 Arthur~~ 413 Chicago St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

74a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 16 - 1867.

7. AGE Years 62. Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer & Stock raiser

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER G. E. Steward

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Victoria Shellhouse

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant George M. Steward

(Address)

15. Filed 10-31-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 30 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1929, to Oct 30, 1929

that I last saw him alive on Oct. 29, 1929

and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. R. Whittenburger M. D.

Oct. 31, 1929 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Canyon Hill

Date of Burial 19

20. Undertaker Paul L Case

Address Caldwell

RECEIVED NOV 13 1929

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 1005

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67929

Local Registrar's No. 118

2. FULL NAME Swain Beatty

(a) Residence. No. 1101 Arthur St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Water Supt

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant D. K. Beatty

(Address) 1101 Arthur St

15. Filed 10-29-, 1929. John B. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 28, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 28, 1929

that I last saw him alive on Oct 28, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. D.

10/29, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Oct 31 1929
20. Undertaker	**Address**
Paul L. Case	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 13 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67930

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 117

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thos. O. Pickard

(a) Residence. No. 912 Belmont St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 20th 1848

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	9	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Retired

9. BIRTHPLACE (city or town) (State or country) Montreal Canada

PARENTS

10. NAME OF FATHER Louis Picard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montreal Canada
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs C. O. Pickard
(Address) Caldwell Ida

15. Filed 10-31-, 1929. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1929, to Oct 27, 1929
that I last saw h[illegible] alive on Oct 27, 1929
and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH* was as follows:
Senile dementia

(duration) one year yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) [illegible], M. D.
10/28, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	10-30 1929

20. Undertaker E. V. Beckham Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67931

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 116

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Haaland. 90

(a) Residence. No. 200 7 Home St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 9-19 1861

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	1	4.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: paper hanger & painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Massachusetts

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs V H Price
(Address) I O O F Home Caldwell Ida

15. Filed 10-26-, 1929 John S. Meyers, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25, 1929 to Oct 26, 1929
that I last saw h~~im~~ alive on Oct 25, 1929
and that death occurred, on the date stated above, at 1 a m.
The CAUSE OF DEATH* was as follows:
Cardiac Embolism

..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Chronic Endocarditis
..... (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms

(Signed) [signature], M. D.
10/26, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Oct 27-29
20. Undertaker	Address
Paul L. Case	Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67932

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 115

(No. 740) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kate Lucas

(a) Residence. No. 603 Decatur St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 9 - 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	1	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Duncan Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Mary McCall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant W. H. Lucas
(Address) Caldwell Ida

15. Filed 10-24-1929 John S. Freyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18, 1929, to Oct 22-, 1929
that I last saw h[illegible] alive on Oct 22, 1929
and that death occurred, on the date stated above, at 8 a.m.
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) High Blood Pressure
(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Paralysis

(Signed) C. M. Taber M. D.
10-23-, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	10-24 1929
20. Undertaker	Address
C. V. Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67933

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 113

2. FULL NAME J.Granville Cowden

(a) Residence. No. 902 Dearborn St. 11B
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 2-9 1837

7. AGE: Years 92, Months 8, Days 12. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Minister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Jamestown Ohio

PARENTS

10. NAME OF FATHER: Alexander Cowden
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Cannonsburg Pa
12. MAIDEN NAME OF MOTHER: Morrow
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: W G Cowden
(Address) Caldwell Idaho

15. Filed 10-23-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 21-29 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12-, 1929, to Oct. 21, 1929
that I last saw him alive on Oct 21, 1929
and that death occurred, on the date stated above, at 2130 P m.
The CAUSE OF DEATH* was as follows: Influenza
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature] M. D.
10-22-, 1929 (Address) Caldwell Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Polo Ills
Date of Burial: 19

20. Undertaker: Paul L.Case
Address: Caldwell Idaho

RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67934

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 111
(No. 126)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred H. Barber.
(a) Residence. No. Caldwell St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 14, 1873

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	8		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Altra, Ill.

PARENTS

10. NAME OF FATHER Myron H. Barber.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York.
12. MAIDEN NAME OF MOTHER Emeline Richmond
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York.

14. Informant Mrs. Florence E. Harriett
(Address) Caldwell, Ida.

15. Filed 10-16-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to Oct 15, 1929,
that I last saw h~~im~~ alive on Oct 15, 1929
and that death occurred, on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:

Acute Nephritis
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis Several.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) J. McCain, M. D.
10/16, 1929 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	10-17-29
20. Undertaker	**Address**
Paul L. Case	Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67935

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 170

PLACE OF DEATH

County of Canyon
City of Wilder
(No. 113)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harold Stevenson

(a) Residence. No. Wilder R#2 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	—

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 12-1917

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
12	4	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wilder Ida

PARENTS

10. NAME OF FATHER Bert Stevenson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Scott Brown
(Address) Wilder Idaho

15. Filed 10-29-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct - 14 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Oct 14, 1929, that I last saw him alive on Oct 14, 1929, and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:
Meningococcic Cerebro Spinal Meningitis.
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Lab Tests Dr. Tallet
(Signed) Robert E Tallet, M. D.
Oct 30, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wilder Cem.	Oct 15 1929

20. Undertaker	Address
C. V. Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67937

PLACE OF DEATH
County of Canyon
City of Caldwell.
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 108
(No. 74A)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Foster H. Bowen.
(a) Residence. No. 812 Belmont St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 29-1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	2	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Vermont,

PARENTS

10. NAME OF FATHER John Bowen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont know
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Mrs. F.H. Bowen
(Address) Caldwell, Ida.

15. Filed 10-15-, 1929 John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct - 13 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929 to Oct 13, 1929
that I last saw him alive on Oct 12, 1929
and that death occurred, on the date stated above, at 12-45 m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) yrs. mos. 26 ds.
CONTRIBUTORY (Secondary) Arterial Sclerosis
(duration) several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) C.R. Whitcomb M. D.
Oct 14, 1929 (Address) Caldwell, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill.	10-15 1929
20. Undertaker	Address
E.V. Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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Esla RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67938

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 9
Primary Registration District No. 2004
Local Registrar's No. 106
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Sterling Moss. 74a

(a) Residence. No. Caldwell #63 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Jessie Moss

6. DATE OF BIRTH (month, day and year): Jan 21 1864

7. AGE: Years 65 | Months 8 | Days 21 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Riceville Iowa

PARENTS

10. NAME OF FATHER: E. N. Moss.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York.
12. MAIDEN NAME OF MOTHER: Elmira Boon.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pennsylvania

14. Informant: Mrs Jessie Moss
(Address) Caldwell Ida

15. Filed 10-14-, 1929. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 12 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9, 1929 to Oct 12, 1929 that I last saw h- alive on Oct 12, 1929 and that death occurred, on the date stated above, at 3-45 P. m.

The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.
10/12, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	10/16 1929
20. Undertaker	Address
C. V. Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 3 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67939

Dr. G.W. Montgomery
Caldwell

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Samuel Baker Webb whodied at Caldwell, Idaho on Oct. 12, 1929
Cause of death given as "Asthema and senility." "Fracture neck of femur."

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Fell in his home

Dr. Montgomery

RECEIVED NOV 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67939

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 10 5
(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Baker Webb.

(a) Residence. No. 410 Everett St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 5 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	74	3	7	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hardy Co. West Virginia

PARENTS
10. NAME OF FATHER George Webb.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia
12. MAIDEN NAME OF MOTHER Martha Burch
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) West Virginia

14. Informant J. E. Webb
(Address) Greenfield Mrs.

15. Filed 10-12-, 1929. John L. Meyer. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Oct 12, 1929
that I last saw h alive on Oct 12, 1929
and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis + senility
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Fracture neck of femur Fell in his home -
(duration) yrs. mos. 18 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? symptoms
(Signed) P. D. Montgomery M. D.
10/12, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Omer Missouri.	
20. Undertaker	Address
E. V. Packham	Caldwell, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67940

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 3
Primary Registration District No. 1005
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 104

2. FULL NAME James Lowe Baker. 34
(a) Residence. No. 1001 Albany St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lillie N. Baker

6. DATE OF BIRTH (month, day and year) Nov-2-1868

7. AGE Years 59 Months 11 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri.

PARENTS

10. NAME OF FATHER James C. Baker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois.
12. MAIDEN NAME OF MOTHER Sarah J. Smoot
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois.

14. Informant Lillie N. Baker
(Address) Caldwell Ida

15. Filed 10-21-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/17/, 1929, to 10/4/, 1929.
that I last saw him alive on 10/4/29, 19..
and that death occurred, on the date stated above, at 5-30 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary embolus.
(duration) 0 yrs. 0 mos. 10 ds.
CONTRIBUTORY (Secondary) Tuberculosis of spine.
(duration) 8 yrs. 0 mos. 0 ds.

18. Where was disease contracted if not at place of death? Caldwell, Idaho.
Did an operation precede death? Yes. Date of 9/23/29.
Was there an autopsy? No.
What test confirmed diagnosis? Auscultation
(Signed) Geo. D. A. Kellogg, M. D.
10/14/, 1929. (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: 10/6 1929

20. Undertaker: C. V. Peckham — Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 5

STATE DAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67941

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

2. FULL NAME Jacob Newman
(a) Residence. No. Soda Springs Ida St. 101a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of Frances Lucinda Newman

6. DATE OF BIRTH (month, day and year) Sept 19th 1852

7. AGE Years 77 Months 1 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ottumwa Iowa

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Frances Lucinda Taylor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Alabama

14. Informant Everett Newman
(Address) Soda Springs Ida

15. Filed 10-24, 1929 Dr Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21, 1929, to Oct 23, 1929
that I last saw her alive on Oct 23, 1929
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
Right Labor Pneumonia
All Labes involved

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) 0

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? 0 Date of
Was there an autopsy? 0
What test confirmed diagnosis? Physical Ex.
(Signed) Eric Kirkley M. D.
10-24, 1929 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs
Date of Burial 10-25 1929

20. Undertaker B. W. Wittman
Address Soda Springs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67942

PLACE OF DEATH
County of Oneida
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
Local Registrar's No. 25

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Etta P. Blackman 90

(a) Residence. No. Moore · Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) unknown

7. AGE Years 65 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Ernest Newman

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS

10. NAME OF FATHER Porter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant James H. Blackman
(Address) Moore Idaho.

15. Filed 10-25, 1929 Dr Russell Tyrrt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 23, 1929, to Oct 23, 1929
that I last saw her alive on Oct 23, 1929
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
Mitral Inf.

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) 0

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? 0 Date of .....
Was there an autopsy? 0
What test confirmed diagnosis? Examination
(Signed) Ellis Karsky, M. D.
10/23/, 1929 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida
Date of Burial 10-25 1929

20. Undertaker E. L. Whetman
Address Soda Springs Ida

RECEIVED NOV 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67943

Local Registrar's No. 24

PLACE OF DEATH

County of Caribou
City of Soda Springs
Registration District No. 82
Primary Registration District No. 2159
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lily May Tweedie

(a) Residence. No. Moore Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed or divorced
HUSBAND of (or) WIFE of D.O. Tweedie

6. DATE OF BIRTH (month, day and year) 1879 Apr. 20

7. AGE: Years 50 | Months 5 | Days 25 | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Holton Kans

PARENTS

10. NAME OF FATHER B. Blosser
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Minerva Blosser
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant D. C. Tweedie
(Address) Moore Idaho.

15. Filed 10-15-, 1929. Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 15th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2, 1929, to Oct 15-, 1929
that I last saw h.er alive on Oct. 14-, 1929
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Bladder

(duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) 0

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? 0 Date of
Was there an autopsy? 0 Cystoscopic E.U.C
What test confirmed diagnosis?
(Signed) [redacted], M. D.
10-15-, 1929 (Address) Soda Springs Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moore Idaho — Date of Burial: 10-18-1929

20. Undertaker: D. C. Whitman — Address: Soda Springs Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67944

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

2. FULL NAME David W. Clawson 45
(a) Residence. No. Blackfoot Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1866

7. AGE Years 63 Months Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant Fred F. Hansen
(Address) Blackfoot Ida

15. Filed 10-8-, 1929 Dr. Russell Tigul Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 20, 1929, to Oct 5, 1929
that I last saw him alive on Oct 5, 1929
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Sigmoid Flexure
..... (duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) 0
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes No Date of Sep. 20, 1929
Was there an autopsy? .....
What test confirmed diagnosis? X-Ray
(Signed) Ben Kausley, M. D.
Oct. 5, 1929 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida — Date of Burial 10-8 1929

20. Undertaker D. Whitman — Address Soda Springs Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 5 1929

PLACE OF DEATH

County of Fremont

City of Conda

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 82

Primary Registration District No. 2159

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67945

Local Registrar's No. 22

2. FULL NAME Doris Gertrude Rogers. 42

(a) Residence. No. ..... Conda Idaho St.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): April 27-1927

7. AGE — Years: 2 | Months: 5 | Days: 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Conda Ida

PARENTS

10. NAME OF FATHER: John J. Rogers.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Paris Idaho

12. MAIDEN NAME OF MOTHER: Emma King.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ovid Ida

14. Informant: John J. Rogers.

(Address): Conda Idaho

15. Filed 10-2-, 1929 O. Russell Tyler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 1st (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-1-, 1929, to Oct. 1-, 1929 that I last saw her alive on Oct.-1-, 1929 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

Instantly

(duration) ..... yrs. ..... mos. / ..... ds.

CONTRIBUTORY (Secondary) 0

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? V

(Signed) Ellis Kaufman M. D.

Oct. 1, 1929 (Address) Conda Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Paris Idaho — Date of Burial: Oct. 3-1929

20. Undertaker: O. L. Whitman — Address: Soda Springs Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67946

PLACE OF DEATH
County of Cassia
City of Almo

Registration District No. 19
Primary Registration District No. 2198
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Thomas Eames 90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Julia Ann Eames.

6. DATE OF BIRTH (month, day and year) Nov. 26 1855

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	8	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Layton Utah

PARENTS

10. NAME OF FATHER Henry Eames
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Emma Beacroft
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Julia Eames
(Address) Almo Idaho

15. Filed Nov 4, 1929 C. E. Sater Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No, 19 to No, 19 29
that I last saw him alive on No, 19
and that death occurred, on the date stated above, at 10:30 A m.
The CAUSE OF DEATH* was as follows:
Probably Valvular heart disease
(duration) yrs. mos. ½ ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. E. Sater M. D.
Nov 4, 1929 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Almo Ida.	Aug. 25 1929
20. Undertaker	Address
D. E. Johnson	Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67947

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George William Hettinger (71)

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married Divorced

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Caroline E Hettinger

6. DATE OF BIRTH (month, day and year) June 13 1872

7. AGE	Years	Months	Days	If LESS than 1 day,
	57	3	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER George Hettinger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Christina E. Muntzert
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Clarence Hettinger
(Address) Boise Ida

15. Filed Oct 15, 1929 F. H Carter
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Wounds in Throat.
Self Inflected
Suicide (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) D. E. Johnson Coroner M. D.
Oct. 2, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida.	Oct 3 1929

20. Undertaker D. E. Johnson
Address Burley

RECEIVED OCT 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67948

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Edna C Jones

(a) Residence. No. 1008 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 26 1845

7. AGE	Years	Months	Days	If LESS than 1 day,
	84	7	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER Washington Wickenson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Mary Wickenson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Rosa Beasley
(Address) Burley Ida

15. Filed Oct 5, 1929 Hunter
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1929, to Sept 28, 1929
that I last saw her alive on Sept 28, 1929
and that death occurred, on the date stated above, at 10:8. m.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(duration) yrs. 26 mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E Jones, M. D.
Oct 2, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Sept. 30 1929
20. Undertaker	Address
W E Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67949

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101 B

2. FULL NAME Gertrude Nordness

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of May 20 1866

6. DATE OF BIRTH (month, day and year)

7. AGE Years 63 Months 4 Days 24 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS
10. NAME OF FATHER Mats Nordness
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Susie Slindee
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Eric Nordness
(Address) Burley Ida

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 24 1929
~~Sep 22~~ (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 22, 1927 to Sep 24, 1929
that I last saw her alive on Sep 24, 1927
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Aortic Stenosis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Usual
(Signed) Joseph Heinstad M. D.
Oct. 10. 1927 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida
Date of Burial Sept. 26 1929

20. Undertaker W. E. Johnson
Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67950

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joe Marian Elquist

113

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 25 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Oakley
(State or country) Idaho

PARENTS

10. NAME OF FATHER Clarence Elquist
11. BIRTHPLACE OF FATHER (city or town) Grantsville
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Bertha Boyce
13. BIRTHPLACE OF MOTHER (city or town) Oakley Idaho.
(State or Country)

14. Informant Clarence Elquist
(Address) Oakley Idaho.

15. Filed Oct 15, 1929. H. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929, to Sept 15, 1929
that I last saw him alive on Sept 15, 1929
and that death occurred, on the date stated above, at 7:30 P. m.
The CAUSE OF DEATH* was as follows:
Enteritis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E. Jones, M. D.
Sept 16, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Oakley Idaho.
Date of Burial: Sept. 17 1929

20. Undertaker: D. E. Johnson
Address: Burley

RECEIVED OCT 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No.

Primary Registration District No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67951

Local Registrar's No.

440

2. FULL NAME Glydas May Merrill

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 17 1910

7. AGE Years 19 Months 4 Days 22 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Albion
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Ivan Merrill

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Smithfield Utah

12. MAIDEN NAME OF MOTHER Carrie Grey

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Albion Idaho.

14. Informant Ivan Merrill
(Address) Burley Idaho.

15. Filed Oct 15, 1929 F. H Carter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 9 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Sept 9, 1929
that I last saw her alive on Sept 9, 1929
and that death occurred, on the date stated above, at 9:15 P. m
The CAUSE OF DEATH* was as follows:
Acute Endocarditis

(duration) yrs. mos. d

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. 39 d

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hugh E Dean, M. I

Sept 20, 1929 (Address) Burley Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLEN CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2 whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Albion Idaho.

Date of Burial Sept. 12 19

20. Undertaker D.E. Johnson

Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67952

PLACE OF DEATH
County of Clark
City of Dubois

Registration District No. 125
Primary Registration District No. 2203

Local Registrar's No.

(No. 100a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Trenidad D Gonzalez

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Jesus Gonzalez

6. DATE OF BIRTH (month, day and year): May 9. 1910

7. AGE — Years: 19 — Months: 3 — Days: 29 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Mexico

PARENTS

10. NAME OF FATHER: Lorenzo Delgado
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mexico
12. MAIDEN NAME OF MOTHER: Angela Martinez
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mexico

14. Informant: Angela Delgado
(Address) Dubois Idaho

15. Filed Sept 8, 1929 C E Jones M D Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5, 1929, to Sept 8, 1929
that I last saw her alive on Sept 8, 1929
and that death occurred, on the date stated above, at 3:20 P m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. about 10 mos. ..... ds.

CONTRIBUTORY (Secondary): Pulmonary tuberculosis

(duration) 1 or more yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C E Jones, M. D.
Sept 8, 1929 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dubois Idaho	Sept 10 1929
20. Undertaker: Cliff C Hays	Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67953

County of Clearwater
City of Orofino
Registration District No. 10
Primary Registration District No. 2187
Local Registrar's No. 106

(No.) 204
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lemire Gleason

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): ?

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 21 1864

7. AGE: Years 64 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): ?

PARENTS

10. NAME OF FATHER: ?
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ?
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

14. Informant W. A. Shaw Coroner
(Address) Orofino Ida

15. Filed Oct 23, 1929 W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 9a m.
The CAUSE OF DEATH* was as follows:

Found dead in bed ta Lumbermans Hotel
Valvar Heart Dease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. A. Shaw Coroner, M. D.
Oct 23, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino Ida — Date of Burial: Oct 25 19

20. Undertaker: W. A. Shaw — Address: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67954

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2157

Local Registrar's No. 165

(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Pauline Rochat

(a) Residence. No. ..... St. St. Maries, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of X
(or) WIFE of

6. DATE OF BIRTH (month, day and year) February 25, 1904

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	7	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sshool girl and domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Maries, Idaho

PARENTS

10. NAME OF FATHER Paul Rochat

11. BIRTHPLACE OF FATHER (city or town) (State or Country) St. Paul, Minnesota

12. MAIDEN NAME OF MOTHER Leah Jacot

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Records, Northern Idaho Sanitarium
(Address) Orofino, Idaho.

15. Filed Oct 22, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to October 18, 1929
that I last saw her alive on October 18, 1929
and that death occurred, on the date stated above, at 6.52 P. m.
The CAUSE OF DEATH* was as follows:

Intestinal tuberculosis

(duration) 1 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Dementia praecox, hebe-phrenic type (duration) 4 yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs

(Signed) John Irvine McKelvey, M. D.
October 18, 1929 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cemetery, No. Idaho Sanitarium	Oct. 21 1929

20. Undertaker	Address
F. A. Billberg, Hosp. Attdt,	Orofino, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67956

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 103

2. FULL NAME Blanche Ubervaga

(a) Residence. No. 220 North Sixth St. Boise - Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day,
	28	2	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) United States

PARENTS

10. NAME OF FATHER Jose Ubervaga
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed Oct 14, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 8 1929, to October 13, 1929
that I last saw her alive on October 12, 1929
and that death occurred, on the date stated above, at 7.40 A. m.
The CAUSE OF DEATH* was as follows:
Exhaustion of psychosis

(duration) ✓ yrs. 3 mos. + ds.
CONTRIBUTORY (Secondary) Psychosis with other brain & Nervous diseases (duration) ✓ yrs. 3 mos. + ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John Irvine McKelvey, M. D.
October 13 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Boise Ida	
20. Undertaker W. A. Shaw	Address Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67957

PLACE OF DEATH
County of Custer
City of Challis

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 93

48B

2. FULL NAME Signa Jensen
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nels C. Jensen

6. DATE OF BIRTH (month, day and year) April 16 1855

7. AGE: Years 74 | Months 5 | Days 6 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Aarons Denmark

PARENTS

10. NAME OF FATHER Sorensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Mrs Julia Calvin
(Address) Challis Ida.

15. Filed Sept 25, 1929 Edna McKenney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1927, to Sept 20, 1929
that I last saw her alive on Sept 20, 1929
and that death occurred, on the date stated above, at 9/20 m.
The CAUSE OF DEATH* was as follows:
Chronic bronchitis & myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. L. Kirtley, M. D.
Oct 30, 1929 (Address) Challis Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Challis, Ida. | Date of Burial: Sept 25 1929

20. Undertaker: Theo Garnier | Address: Mackay, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67958

PLACE OF DEATH
County of Custer
City of Stanley

Registration District No. 108
Primary Registration District No. 2186
(No. Died in his Cabin)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 94

2. FULL NAME Albert Robert Smith
(a) Residence. No. Stanley Custer Co. Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Single
6. DATE OF BIRTH (month, day and year): 1859
7. AGE Years: 70 Months: X Days: X If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Lead & Silver Mines
(b) General nature of industry, business, or establishment in which employed (or employer): working mines
(c) Name of employer: X
9. BIRTHPLACE (city or town) (State or country): Pottsville Sch. Co. ~~Penna~~. Pa.

PARENTS
10. NAME OF FATHER: George M Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Sarah W. Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Sadie Wood Husbaum
(Address): 5002 Walnut St Phila

15. Filed Oct 20, 1929 Edna McKenney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 30th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ___, 19___, to ___, 19___
that I last saw h___ alive on ___, 19___
and that death occurred, on the date stated above, at ___ m.
The CAUSE OF DEATH* was as follows:
pneumonia
no doctor in
attendance (duration) ___ yrs. ___ mos. ___ ds.
CONTRIBUTORY (Secondary) ___
___ (duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ___ Date of ___
Was there an autopsy?
What test confirmed diagnosis?
(Signed) ___, M. D.
___, 19___ (Address) ___

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Stanley Idaho
Date of Burial: Oct 2 1929
20. Undertaker: Friends
Address: Stanley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67959

PLACE OF DEATH
County of Elmore
City of Glenns Ferry

Registration District No. 35
Primary Registration District No. 2021
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Mrs Clementine A Warren 164
(a) Residence. No. Glenns Ferry Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 12 - 1844

7. AGE: 85 Years | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) New Hampshire

PARENTS
10. NAME OF FATHER Chapman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Hampshire
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Lydia Warren
(Address) Glenns Ferry Ida

15. Filed 10-13, 1929 Mrs. Mary Sullivan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 12 1929, to Oct 12, 1929
that I last saw her alive on Oct. 12, 1929
and that death occurred, on the date stated above, at 4 30 p. m.
The CAUSE OF DEATH* was as follows:

Senility
(duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Old age
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. W. Davis, M. D.
10-12-, 1929 (Address) Glenns Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Glenns Ferry Ida
Date of Burial: 10-17 1929

20. Undertaker: G. C. Zacher
Address: Mt. Home

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67960

PLACE OF DEATH

County of Elmore
City of Glenns Ferry
Registration District No. 35
Primary Registration District No. 2021
Local Registrar's No.
(No.) 49
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John W. Latty Jr.

(a) Residence. No. Glenns Ferry Ida (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 30 yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Lillian Maxwell Latty

6. DATE OF BIRTH (month, day and year) Sept 16 - 1899

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30		22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Grocery Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) General Store
(c) Name of employer G. R. Baker

9. BIRTHPLACE (city or town) (State or country) Glenns Ferry Idaho

PARENTS
10. NAME OF FATHER John W. Latty. Sr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) McDonald County Mo.
12. MAIDEN NAME OF MOTHER Mary Frances Sandy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Clay County Mo

14. Informant Dow Maxwell
(Address) Glenns Ferry Ida

15. Filed 10-16, 1929 Mary L. Sullivan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8, 1929, to Oct 8, 1929
that I last saw him alive on October 8, 1929
and that death occurred, on the date stated above, at 7 15 P. m.
The CAUSE OF DEATH* was as follows:
Virginia Pectoris
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L W Davis M. D
Oct 10, 1929 (Address) Glenns Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Glenns Ferry Ida.	10-11 1929

20. Undertaker G. C. Zacher Address Mt Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67961

PLACE OF DEATH
County of Elmore
City of Glenns Ferry

Registration District No. 35
Primary Registration District No. 2021
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

146

2. FULL NAME Mrs. Maxine Elva Maxwell

(a) Residence. No. Glenns Ferry Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, ~~widowed, or divorced~~
~~HUSBAND of~~
(or) WIFE of Dale Maxwell

6. DATE OF BIRTH (month, day and year) May 2- 1907

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
22	3	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Alice Oregon

PARENTS

10. NAME OF FATHER R. F Case
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Arkansas
12. MAIDEN NAME OF MOTHER Grace Simmons
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas

14. Informant Dale Maxwell
(Address) Glenns Ferry Idaho

15. Filed 9-14, 1929 Mrs Mary Sullivan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1929, to Aug 4, 1929
that I last saw her alive on Aug 4, 1929
and that death occurred, on the date stated above, at 5 30 P. m.
The CAUSE OF DEATH* was as follows:

puerperal sepsis
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Adherant placenta
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical.
(Signed) J W Davis, M. D.
Aug 5, 1929 (Address) Glenns Ferry

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Glenns Ferry	Aug 6- 1929
20. Undertaker	Address
G C Zacher	Mt Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67062

PLACE OF DEATH
County of Elmore
City of Glenns Ferry
Registration District No. 35
Primary Registration District No. 2021
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Mrs Josephine Amelia Corker 47

(a) Residence. No. Glenns Ferry St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Walter G. Corker

6. DATE OF BIRTH (month, day and year) May 14- 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	4	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Battle Mountain Nevada

PARENTS

10. NAME OF FATHER R. G. Rhodes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Richmond Virginia
12. MAIDEN NAME OF MOTHER Margaret V. Rhodes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wood Ohio

14. Informant Mary E. Rhodes
(Address) 498- 30th St. Oakland Calif

15. Filed Aug 31, 1929 Mrs Mary Sullivan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15, 1929, to Aug 30, 1929
that I last saw her alive on Aug 30, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Carcinoma of breast followed by metastasis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 9-2
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. W Davis, M. D.
Aug 31, 1929 (Address) Glenns Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Glenns Ferry Ida	Sept 1 1929
20. Undertaker	Address
G C Zacher	Mt Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Child adopted by Mr & Mrs H B Meisinzahl

RECEIVED OCT 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67963

PLACE OF DEATH

County of Elmore
City of Glenns Ferry

Registration District No. 35
Primary Registration District No. 2021
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

198

2. FULL NAME Marie Eldore West Meisinzahl

(a) Residence. No. Glenns Ferry Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) March 10-1918

7. AGE: Years 11, Months 6, Days 9. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

10. NAME OF FATHER: West

11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Goff

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

PARENTS

14. Informant: H B Meisinzahl
(Address) Glenns Ferry Idaho

15. Filed 10-5, 1929 Mrs Mary Sullivan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Homicidal - Murdered by party or parties unknown throat cut and body thrown in Snake River (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Grant Hughes Coroner
Sept 20, 1929 (Address) Glenns Ferry

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Glenns Ferry Ida
Date of Burial: Sept 22 1929

20. Undertaker: G C Zacher
Address: Mt Home Ida

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67965

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No.
(No.) 162
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Evangeline Guillen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Mixican	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 27 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	8	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Leadville Colo

PARENTS

10. NAME OF FATHER Toney Guillen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Mexico
12. MAIDEN NAME OF MOTHER Stephon Masdoses
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New Mexico

14. Informant Toney Guillen
(Address) Preston Idaho

15. Filed Oct. 26, 1929 A R Quiles Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1929, to Oct 25, 1929
that I last saw h[illegible] alive on Oct. 25, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Cholera Infantum
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Eugene L Stokes M. D.
Oct 26, 1929 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Oct 27 29

20. Undertaker	Address
M.W.Hendricks	Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67966

PLACE OF DEATH

County of Fremont

City of Lake

Registration District No. 99

Primary Registration District No. 2177

Local Registrar's No. 294

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

142

2. FULL NAME William T. Smoot

(a) Residence. No. Salt Lake City, Utah. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 30-1883

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	1	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work General Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Salt Lake City
(State or country) utah

PARENTS

10. NAME OF FATHER W. T. A. Smoot

11. BIRTHPLACE OF FATHER (city or town) Not Known
(State or Country)

12. MAIDEN NAME OF MOTHER Mahala Garn

13. BIRTHPLACE OF MOTHER (city or town) Not Known
(State or Country)

14. Informant Mrs W. T. Smoot
(Address) Salt Lake City, Utah

15. Filed Aug. 13th, 19 29 W. M. Hansen
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 12th, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Accidential Drowning while
fishing on Henry's Lake

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Boat Upsetting.

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. M. Hansen, M. D.

Aug. 13th, 1929 (Address) County Coroner St. Anthony Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salt Lake City, Utah	Aug. 18 1929

20. Undertaker W. M. Hansen Address St. Anthony, Idaho.

RECEIVED NOV 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67967

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma R. Kelley
(a) Residence. No. St. 49
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	white	widow

a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 19-1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	5	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Wapella
(State or country) Illinois

PARENTS

10. NAME OF FATHER Thos H. Robertson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Mary Gibson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Mrs. Clare Shabre
(Address) Emmett Idaho

15. Filed 11/1, 1929 J.L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from about 11 to months, 19
that I last saw her alive on about 60 days
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Cancer of face and scalp
(duration) 1 yrs. or more mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J.L. Reynolds, M. D.
11-2-29, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Ida	11/1 1929
20. Undertaker C.D. Buckmann	Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67968

PLACE OF DEATH

County of Ada

City of Emmett

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1489

2. FULL NAME Joseph Morache

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Mary Morache

6. DATE OF BIRTH (month, day and year) Feb 8 - 1869

7. AGE: Years 60 | Months 8 | Days 15 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Saw Mill worker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Toledo Ohio

PARENTS

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Quebec - Canada

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Joseph R. Morache
(Address): Emmett Ida

15. Filed 10/26, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Body was crushed when the boo
arm of a derrick fell upon him.
Boise Payette Lbr. Mill
death was accidental.

yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. C. Adkins Coroner M.D.

10/26, 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	Oct 26 1929

20. Undertaker	Address
C. D. Buckner	Emmett Idaho

RECEIVED NOV 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67969

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No.
Primary Registration District No. 6
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ira L. Burton 90

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 19 - 1844

7. AGE	Years	Months	Days	If LESS than 1 day,
	85	3	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Ina Goodwin
(Address) Emmett Ida

15. Filed 10/7, 1929 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1928, 19, to Oct 7 -, 1929
that I last saw h~~im~~ alive on Oct 6, 1929
and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
followed with Uremia

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) J L Reynolds
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
10/7, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Ida	10/10 1929

20. Undertaker C D Bucknum Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67970

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. 6
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oliver Elbert Sherard

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Laura Sherard

6. DATE OF BIRTH (month, day and year) Apr 26 - 1875

7. AGE Years 54 Months 6 Days 11 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoe Repairer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mayville Mo

PARENTS
10. NAME OF FATHER Henry Sherard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cheyenne Wyo
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant N. S. Fuller
(Address) Missoula Mont

15. Filed 10/9, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 7 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1929, to Oct 7, 1929
that I last saw him alive on Oct 7, 1929
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Paralysis -
This was a case of Hemoplegia.
(duration) about 15 days yrs. mos. ds.
CONTRIBUTORY (Secondary) unknown except arteriosclerosis Present
Unknown (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) N B Barnes D.D.
10/9, 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho
Date of Burial: 10/9 1929

20. Undertaker: C D Bucknum
Address: Emmett Idaho

RECEIVED NOV 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67971

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. 6
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

542

2. FULL NAME Mrs Minnie Hardin Brown

(a) Residence. No. R F D St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of E W Brown

6. DATE OF BIRTH (month, day and year) Apr 16 1871

7. AGE	Years	Months	Days	If LESS than 1 day,
	58	5	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wheeling Iowa

PARENTS

10. NAME OF FATHER Leander Hardin

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Martha Hollowell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant E W Brown
(Address) Emmett Idaho

15. Filed 10-10, 1929 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 9 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to Oct 9, 1929
that I last saw h[illegible] alive on Oct 9th, 1929
and that death occurred, on the date stated above, at 10-30 a.m.
The CAUSE OF DEATH* was as follows:
Pernicious Anemia
Do not know
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Do not know
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) J L Reynolds, M. D.
10-10, 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Indianola Iowa
Date of Burial 19

20. Undertaker Paul L.Case
Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67972

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ida Josephine Gamble 44

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: wht
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ D. W. Gamble

6. DATE OF BIRTH (month, day and year) Nov 26 - 1856

7. AGE Years 72 Months 10 Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER Levi Pritchard
11. BIRTHPLACE OF FATHER (~~city or~~ town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Margaret Campbell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ontario, Canada

14. Informant Mrs Ella Stevison
(Address) Boise Idaho

15. Filed 9/30, 1929 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 28, 1929
that I last saw her alive on Sept 23, 1929
and that death occurred, on the date stated above, at ✓ m.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J L Reynolds, M. D.
9/30, 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Ida
Date of Burial: 9/30 1929

20. Undertaker: C D Bucknum
Address: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. RECEIVED NOV 4 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24

File No. 67973

Primary Registration District No.

Registered No. 108

1. PLACE OF DEATH

County of

City of (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles H. Alban

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: January 21st. 1 (Month) (Day) (Year)

7. AGE: 71 Yrs. 9 Mos. 8 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mining

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fay W. Alban

(Address) Gooding Idaho

15. Filed 10/31 1929

J. F. Cranmall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1929 to Oct 29 1929 that I last saw him alive on Oct 29 1929 and that death occurred on the date stated above, at 8:35 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. 21 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Houston E Snyder M. D.

10-30 1929 (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67971

Local Registrar's No. 107

PLACE OF DEATH

County of Gooding

City of Gooding

Registration District No. 24

Primary Registration District No.

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Walter Radams

(a) Residence. No. St. 1010

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Irene Adams.

6 DATE OF BIRTH (month, day and year) Jan-27-1883

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
46.	9.	19-	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Sedalia Mo

PARENTS

10 NAME OF FATHER Elija Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Louisville Ky

12 MAIDEN NAME OF MOTHER M V Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Missouri

14 Informant C. W. Adams

(Address) Gooding Ida

15 Filed 10/31, 1929 J H Cranmer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 (Month) 14 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 10-4-, 1929, to 10-14, 1929, that I last saw him alive on 10-14, 1929, and that death occurred, on the date stated above, at 4:10 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ... yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Weiss Idaho

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Houston & Snyder, M. D.

10-17, 1929 (Address) Gooding Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Elmwood Cemetery Gooding — Date of Burial: 10/17 1929

20. Undertaker: A. E. Thompson — Address: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67975

PLACE OF DEATH,
County of Lunding
City of Hagerman

Registration District No. 39
Primary Registration District No. 2087
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Rosa Williams

44

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of T. J. Williams

6. DATE OF BIRTH (month, day and year) Aug 4 - 1868

7. AGE Years 61 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Macon Co. Mo.

PARENTS

10. NAME OF FATHER Milton Forbis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Ellen Lovern
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant L. Warren Williams
(Address) Felt Ida.

15. Filed 10 - 4, 1929. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1929, to 10 - 3, 1929
that I last saw her alive on 10 - 3 -, 1929
and that death occurred, on the date stated above, at 5:30 a. m.
The CAUSE OF DEATH* was as follows: Cancer of Liver.

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of 7-25-29
Was there an autopsy? No
What test confirmed diagnosis? Exploratory
(Signed) Geo. Jennings, M. D.
10 - 3 -, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hagerman Ida
Date of Burial Oct 5th 1929

20. Undertaker L. J. Johnson
Address Buhl Ida.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67976

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 2181
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 39

129

2. FULL NAME John McCloud

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1840

7. AGE Years 89 Months - Days - If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nova Scotia

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant B. Chipman
(Address) Grangeville Ida.

15. Filed 11-2-, 1929 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 3 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27, 1929, to Oct. 3, 1929
that I last saw him alive on Oct. 3, 1929
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis
..... (duration) 5 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Summary findings
(Signed) B. Chipman M. D.
Oct. 5, 1929 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville Ida. Date of Burial 10-4-1925

20. Undertaker Hancock Mfg. Co. Address Grangeville Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67977

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 2181
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 38

2. FULL NAME Henry G. (Doct) Denney 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1864

7. AGE Years 65 Months - Days - If LESS than 1 day ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Gardner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) California

PARENTS
10. NAME OF FATHER —
11. BIRTHPLACE OF FATHER (city or town) (State or Country) —
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant G. W. Edwards
(Address) Grangeville Ida.

15. Filed 11-2-, 1929 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 25 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 -, 1927, to Oct. 24 -, 1929
that I last saw him alive on Oct. 24 -, 1929
and that death occurred, on the date stated above, at 5-9. m.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis and Chronic Myocarditis
(duration) 3 yrs. - mos. - ds.
CONTRIBUTORY (Secondary) Chronic Alcoholism
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Heart findings
(Signed) B Chipman, M. D.
Oct. 28, 1929 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville Ida. Date of Burial 10-27 1929

20. Undertaker Hancock Mnf. Co. Address Grangeville Ida.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67978

PLACE OF DEATH
County of Idaho
City of Harpster

Registration District No. 103
Primary Registration District No. 2181
Local Registrar's No. 37
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charlott Wasmundt

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Fred Wasmundt

6. DATE OF BIRTH (month, day and year) Aug 29 - 1907

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	1	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Bartlettsville Okla.

PARENTS

10. NAME OF FATHER Geo. Payton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Okla.

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant Fred Wasmundt
(Address) Harpster Ida.

15. Filed 11-2-, 1929 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 2- 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10-, 1929, to Sept. 30-, 1929
that I last saw her alive on Sept. 30, 1929
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? Physical Condition
(Signed) B. Chipman, M. D.
Oct. 10, 1929 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harpster Ida	10-4-1929
20. Undertaker	Address
Geo. Jeremary	Kooskia Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 31 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67979

PLACE OF DEATH
County of Jerome
City of Jerome
Registration District No. 18
Primary Registration District No.
Local Registrar's No.
(No.) 74 W
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alva Lewis Smith

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 21 1929

7. AGE — Years | Months | Days: 3 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Jerome Idaho

PARENTS

10. NAME OF FATHER: Thomas Elmer Arthur Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country): St Louis Mo.
12. MAIDEN NAME OF MOTHER: Viola Josephine Lewis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Clearwater Co Kans

14. Informant: Mrs Emily Lamm
(Address): Jerome Idaho

15. Filed 9/26, 1929. Chas F Zeller Jr. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/21, 1929, to 9/23, 1929, that I last saw him alive on 9/23, 1929, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. D. Weaver M. D.
9/24, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Date of Burial: Sept 25 1929

20. Undertaker: none
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 6-25 M. 1-10

RECEIVED OCT 31 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 67980

Registered No.

Registration District No.

Primary Registration District No.

(No. , St.)

1. PLACE OF DEATH

County of Jerome

City of Jerome

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry B. Weka

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 23 (Day) 1875 (Year)

7. AGE: 54 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: H. V. Weka

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Weka

(Address) Jerome Idaho

15. Filed 8/23 1929

C. T. Zeller
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 15 1929 to Aug 21 1929 that I last saw h.. alive on Aug. 28 1929 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Haemorrage from Abscess of Lung result of Miners Tuberculosis

(Duration) 15 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. T. Zeller M. D.

19 (Address) Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Idaho

DATE OF BURIAL: Aug 23 1929

20. UNDERTAKER: D A Stevenson

ADDRESS: Jerome Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jerome

City of Hazelton

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18

Primary Registration District No.

(No. , St.)

File No. 67981

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alvin McAllister

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Not Known (Write the word.)

6. DATE OF BIRTH: Not Known (Month) (Day) 1 (Year)

7. AGE: 37 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer on farm

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. W. Potter

(Address) Eden Idaho.

15.

Filed 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

176

16. DATE OF DEATH: Sept 19 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~19~~, ~~to~~ ~~19~~, that I last saw h ~~alive on~~ ~~19~~, and that death occurred on the date stated above, at about 2 A.M.

The CAUSE OF DEATH* was as follows:

Burned to death when house burnt down, from unknown cause

(Duration) ~~Yrs.~~ ~~mos.~~ ds.

Contributory (Secondary)

(Duration) ~~yrs.~~ ~~mos.~~ ds.

(Signed) J R Wiley (Coroner) M.D.

Sept 21 1929 (Address) Jerome, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer Idaho.

DATE OF BURIAL: 10/18 1929

20. UNDERTAKER: F. E. Drake.

ADDRESS: Twin Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED OCT 31 1929

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 67982

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Jerome

City of Jerome (No. 49, St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

2. FULL NAME Horatio Chas Browne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Apr 14 1878 (Month) (Day) (Year)

7. AGE: 51 yrs. 3 mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: William Horton Browne

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Josephine Rand

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. R. Browne
(Address)

15. Filed 7/16 1929 C. E. Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 14 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1929, to July 14 1929, that I last saw him alive on July 14 1929, and that death occurred on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. E. Zeller M. D.

7/16 1929 (Address) Jerome, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City, Utah

DATE OF BURIAL: 191

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jerome

City of Jerome

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18

Primary Registration District No.

(No. , St.)

File No. 67983

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John A. Gifford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Oct (Month) 29 (Day) 1830 (Year)

7. AGE: 93 Yrs. 11 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Gifford

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C C Stevens

(Address) Jerome Idaho

15. Filed 10/28 1929

Chas F Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1929, to Oct 29 1929 that I last saw him alive on Oct 28 1929 and that death occurred on the date stated above, at 8:30 a.m. M.

The CAUSE OF DEATH* was as follows:

myocarditis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary): Prostatitis

(Duration) 10 yrs. mos. ds.

(Signed) Johnt Schmershall M. D.

Oct 29 1929 (Address) Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer Idaho

DATE OF BURIAL: Oct 28 1929

20. UNDERTAKER: L Hirsson

ADDRESS: Jerome Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67984

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 150

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas. A Berry

(a) Residence. No. 721 — 3rd St. 38

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Berry

6. DATE OF BIRTH (month, day and year) April 7 - 1863

7. AGE Years 66 Months 6 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired 5 yrs

(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10. NAME OF FATHER E F Berry

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Judith Hardy

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vermont

14. Informant Mrs Emma Berry

(Address) Coeur d'Alene Ida

15. Filed 10-29, 1929 H. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1929, to Oct. 19, 1929

that I last saw him alive on Oct. 18, 1929

and that death occurred, on the date stated above, at 1:15 P m.

The CAUSE OF DEATH* was as follows: Cerebral Lues.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wasserman

(Signed) John O Wood, M. D.

Oct. 21, 1929 (Address) Coeur d'Alene Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Forest Cemetery

Date of Burial 10-22 1929

20. Undertaker R B Downey

Address Coeur d'Alene

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67985

PLACE OF DEATH
County of Kootenai
City of Coeur D' Alene
Registration District No. 30
Primary Registration District No. 1650
Local Registrar's No. 148

(No. 403)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Belle Phillips

(a) Residence. No. 410 Foster Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 22, 1849

7. AGE	Years	Months	Days	If LESS than 1 day,
	81	3	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10. NAME OF FATHER Thomas Narey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Mrs. Kate Mason,
(Address) 5701 New Hampshire ave. Los Angles, Cal.

15. Filed 10-28, 1929 H. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1929 to Oct. 9, 1929
that I last saw h[illegible] alive on Oct. 8, 1929
and that death occurred, on the date stated above, at 5:30 A m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) Not known yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J. O'Meara, M. D.
Oct 12, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. ~~Place of Burial~~, Cremation, or Removal	Date of Burial
Spokane Burn	Oct 14 1929

20. Undertaker P B Mooney Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67986

Registration District No. 38
Primary Registration District No. 1050
Local Registrar's No. 149

164

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ezra N. McLean

(a) Residence. No. Colbert Road St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	Mid

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of, Nettie F. McLean

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61 - 6mo. 5da	8ps	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lockport N.Y.
(State or country)

PARENTS

10. NAME OF FATHER Wm McLean
11. BIRTHPLACE OF FATHER (city or town) Scotland
(State or Country)
12. MAIDEN NAME OF MOTHER Mary Elderman
13. BIRTHPLACE OF MOTHER (city or town) Not known
(State or Country)

14. Informant Mrs E L Brown
(Address) 1324 Lakeside, Coeur d'Alene Ida

15. Filed 10-27, 1929. M. J. Sherman
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1929, to Oct. 17, 1929
that I last saw h~~im~~ alive on Oct 16, 1929
and that death occurred, on the date stated above, at 10 30 P m.
The CAUSE OF DEATH* was as follows;

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis
(Signed) J. C. Dwyer, M. D.
Oct 26, 1929 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane (Wash.)	10-27 1929
20. Undertaker	Address
Smith & Co	Spokane Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

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RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67987

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1650
Local Registrar's No. 151
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Arthur Stewart
(a) Residence. No. 1102 - N. 2nd St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1889

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1911 - 1 - 3

7. AGE	Years	Months	Days	If LESS than 1 day,
	18	9	12	....hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Teamster & Logger
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer Winton Lbr Co.

9. BIRTHPLACE (city or town) (State or country) W —

PARENTS

10. NAME OF FATHER Fred A. Stewart
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Gallup. New Mex.
12. MAIDEN NAME OF MOTHER Prudence Pettis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Eau Claire Wis.

14. Informant Alice M. Clark.
(Address)

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw h... alive on ....., 19....
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Accidental - Crushed by a log —
(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death? Camp #6 Winton Lbr Co
Did an operation precede death? no Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? —

(Signed) Harold D. Stringer, M. D.
10-18, 1929 (Address) Post - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CDAlene	10 - 20 1929
20. Undertaker	Address
Cassedy Funeral Home	CDAlene

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67988

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 152

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rose A. Stillinger

(a) Residence. No. 1319 N. 11th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

7403

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	married

5a. If married, widowed, or divorced ~~(HUSBAND)~~ of (or) WIFE of G.W. Stillinger

6. DATE OF BIRTH (month, day and year) 1858 - 4 - 22

7. AGE	Years	Months	Days	If LESS than 1 day,
	71	5	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10. NAME OF FATHER Geo. Hobson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ada. Ind.
12. MAIDEN NAME OF MOTHER Elvira Prather
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind.

14. Informant G W Stillinger
(Address)

15. Filed 10-18, 1929. K. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 7, 1929, to October 13, 1929
that I last saw h~~e~~r alive on October 13 1929
and that death occurred, on the date stated above, at 8 a.m.
The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. 1 1/2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? /
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No

(Signed) Harold T. Anderson, M. D.
October 15, 1929 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Vellisca, Iowa.	10-22 1929
20. Undertaker Cassedy Funeral Home	Address Coeur d'Alene Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67989

PLACE OF DEATH
County of Kootenai
City of Appleway
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 153
(No. 188 C)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Monk
(a) Residence. No. ... St. Spokane Wn
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 5, 1905

7. AGE	Years	Months	Days	If LESS than 1 day,
	24	5	4	... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Governess
(b) General nature of industry, business, or establishment in which employed (or employer) 2 B Hauls
(c) Name of employer Spokane Wn

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Frank H Monk
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Anna May Thomas
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kan

14. Informant Frank H Monk
(Address) Hamilton Mont.

15. Filed Nov 4, 1929 A. J. Stringer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:
Chest Crushed (Auto accident on Appleway 2 Miles West Post Falls)

... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? ... Date of ...
Was there an autopsy? ...
What test confirmed diagnosis? ...

(Signed) R B Mooney Thom M. D.
Nov 5, 1929 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation,~~ or Removal	Date of Burial
Hamilton Mont	Nov 7 1929

20. Undertaker ... Address ...
R B Mooney Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67990

PLACE OF DEATH
County of Latah
City of Troy
Registration District No. 64
Primary Registration District No. 2144
(No. Troy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

1002

2. FULL NAME Peter Olson

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Alma Olson

6. DATE OF BIRTH (month, day and year) May 22 1866

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Olaf Olson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Marie Erickson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Wilford Olson
(Address) Troy Ida

15. Filed Oct 31, 1929 Sidney M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1929, to Oct 25, 1929
that I last saw him alive on Oct. 25, 1929
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(duration) ..... yrs. ..... mos. 6 ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? .....
(Signed) Chas. A. Meyer, M. D.
10-27, 1929, (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
West Lala cem	Oct 29 1929
20. Undertaker	Address
John J. Pickerd	Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67991

PLACE OF DEATH

County of Latah Registration District No. 101

City of Moscow Primary Registration District No. 2141

(No. R.F.D. No. 5) Local Registrar's No. 47

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Arthur F Irwin

(a) Residence. No. ..... St. W3

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lena Irwin

6 DATE OF BIRTH (month, day and year) Sept. 15, 1865

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
64	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Lafett Lafayette Indiana

PARENTS

10 NAME OF FATHER John Irwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Anna Irwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant G.R. Beckman

(Address) Moscow, Idaho

15 Filed Oct 19, 1929 W. H. Carruthers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 19, 1929 (Month) (Day) 19... (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to Oct 19, 1929, that I last saw him alive on Oct 19, 1929, and that death occurred, on the date stated above, at 2.30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. H. Adair, M. D.

10/22 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow	10/22/29 19

20. Undertaker F. R. Short Address Moscow

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67992

PLACE OF DEATH
County of Latah
City of Moscow. (rural)

Registration District No. 101
Primary Registration District No. 2141

Local Registrar's No. 52

(No.) 482
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucy P. Jeffery

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
eFemale	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James M. Jeffery

6. DATE OF BIRTH (month, day and year) Sept. 4, 1849

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	1	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mineral Point Wis.

PARENTS

10. NAME OF FATHER Thos. Hewett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Ann Webster

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant James M. Jeffery
(Address) Moscow, Idaho

15. Filed Oct 11, 1929 W. H. Matthews Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Cotcher 11/ 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13, 1926, to Oct 11 - 1929
that I last saw h[illegible] alive on Sept 29, 1929
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Focal infection
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. L. Gritman, M. D.
10/13, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	10/13/29 19
20. Undertaker F. R. Short	Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67993

PLACE OF DEATH

County of Latah

City of Moscow (rural)

Registration District No. 61

Primary Registration District No. 2141

Local Registrar's No. 50

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Katherine Byers

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 15 yrs. mos. ~~15~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Ed Byers

6. DATE OF BIRTH (month, day and year) March 8, 1877

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	6	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chicago Ill.

PARENTS

10. NAME OF FATHER Anton Meister

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant W. J. Bruegeman
(Address) Moscow, Ida.

15. Filed Oct 7, 1929 W. H. Carruthers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 7, 1929 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1929, to Oct. 7, 1929
that I last saw her alive on Oct. 7, 1929.
and that death occurred, on the date stated above, at 3:20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

about 20 yrs. ..... mos. ..... ds.
(duration)

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) J. Harry Einhorn, M. D.

10/8/29, 19.. (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Johnson, Wash	10/9/29 19

20. Undertaker	Address
H. R. Short	Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 67994

PLACE OF DEATH

County of Latah
City of Moscow

CERTIFICATE OF DEATH

Registration District No. 101
Primary Registration District No. 2141
(No. County Home)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 410

2. FULL NAME Adam Carrico

(a) Residence. No. ..... St. 119
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not known

6 DATE OF BIRTH (month, day and year): Sept 25, 1842

7 AGE: Years 87, Months 1, Days 5; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ill.

PARENTS
10 NAME OF FATHER: Not known
11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known
12 MAIDEN NAME OF MOTHER: Not known
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mrs. Daisy McCall
(Address): Potlatch, Ida.

15 Filed Oct 30, 1929 W. H. Carriners Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 30, 1929 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to Oct 29, 1929, that I last saw him alive on Oct 29, 1929, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows: Perforation of bowel and peritonitis - all symptoms indicated a chronic gastric or duodenal ulcer with perforation & peritonitis. (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary): old age & exhaustion
(duration) about 84 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? General Condition
(Signed) F. M. Leitch, M. D.
10/31, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Fruit Cemetery (Moscow)
Date of Burial: 11/4 1929

20. Undertaker: F. R. Short
Address: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 5 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67994

Dr. F.M. Leitch
Moscow
Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Adam Carrico who died at Moscow, Idaho on Oct. 30, 1929.
Cause of death given as "Perforation of bowel and peritonitis."

Information DESIRED in order to complete certificate:

PLEASE STATE CAUSE OF PERFORATION OF BOWEL.

PLEASE ANSWER BELOW:

all symptoms indicated a chronic ulcer gastric or duodenal with perforation and peritonitis

Dr. F. M. Leitch

DEC 13 1991

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67995

PLACE OF DEATH

County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 51
(No. Inland Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alexander Vivian Mc Queen

(a) Residence. No. 14a St.
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 17, 1852

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	10	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dover Mo.

PARENTS

10. NAME OF FATHER Geo. McQueen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vir.
12. MAIDEN NAME OF MOTHER Turley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vir.

14. Informant Sallie McQueen
(Address) Moscow Ida.

15. Filed Dec 6, 1929 W. H. Weatherers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 6, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3rd, 1929, to Oct 3rd, 1929, that I last saw him alive on Oct 3rd, 1929, and that death occurred, on the date stated above, at 12:30 a m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Coma
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) E. Magee, M. D.
10/7, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	10/8/29

20. Undertaker H. R. Short Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 67997

PLACE OF DEATH

County of Latah

City of Moscow

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 49

2. FULL NAME MARY RAMSTEDT

(a) Residence. No. St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

161 B

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Allen Ramstedt

6 DATE OF BIRTH (month, day and year): Jan. 18, 1840

7 AGE: Years 89, Months 8, Days 29. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Sweeden

PARENTS

10 NAME OF FATHER: Jacobson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweeden

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweeden

14 Informant: Victor Ramstedt

(Address): Moscow Idaho

15 Filed Dec 17, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 16 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1929, to Oct. 16, 1929, that I last saw her alive on Sept 16, 1929, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows: Pneumonia, (Static)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Fracture of right hip. Stumbled and fell breaking hip.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. O. Armstrong, M. D.

10/17/ 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Moscow Idaho

Date of Burial: 10, 20, 1929

20. Undertaker: H. R. Short

Address: Moscow

RECEIVED APR 14 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

67997

Dr. C.O. Armstrong
Moscow, Idaho

Dear Doctor:

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Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Mary Ramstedt who died at Moscow, Idaho on Oct. 16, 1929.
Cause of death given as "Pneumonia (static)" "Fracture of rt. hip."

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE CAUSE OF DEATH. IF AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Stumbled and fell breaking hip.

O.O. Armstrong M.D.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67998

PLACE OF DEATH

County of Latah,
City of Juliaetta.

Registration District No.
Primary Registration District No. 63
Local Registrar's No.
(No. 129)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Naaman Brubaker.

(a) Residence. No. St. Van Vert, Ohio.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 12/12/1849.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79.	8.	19.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER Peter Brubaker.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Catherine Dull.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant Mrs W. H. Nesbit
(Address) Juliaetta, Idaho.

15. Filed Sept 11, 1929 B. F. Nesbit
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
September 11th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
June 1, 1929, to Sept 10, 1929
that I last saw him alive on Sept. 10, 1929
and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:
Nephritis Chronic
an unknown duration
(duration) several yrs. mos. ds.
CONTRIBUTORY (Secondary) Insufficiency
Uraemia Partial
(duration) several yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ohio
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical + Lab.
(Signed) E. H. Rudd, M. D.
9/12/29. 19 (Address) Kendrick, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Van Vert, Ohio.	
20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67999

Registration District No. 63
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Latah
City of Kendrick
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hugh D. Stanton

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 42 yrs. abt mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

131

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Clara A. Stanton

6. DATE OF BIRTH (month, day and year) Oct. 21 - 1882

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	11	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Postmaster
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer U. S. P.O. Dept.

9. BIRTHPLACE (city or town) (State or country) Coulton Ida.

PARENTS

10. NAME OF FATHER Wm Stanton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Garrett Ky.
12. MAIDEN NAME OF MOTHER Susan Amanda Gaffney
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Garrett Ky.

14. Informant Mrs. Audrey Davenport
(Address) Kendrick, Ida.

15. Filed Oct 5, 1929 B.F. Neabet. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Oct. 4, 1929
that I last saw him alive on Oct. 4, 1929
and that death occurred, on the date stated above, at 6:25 P. m.
The CAUSE OF DEATH* was as follows:

Uremia
from chronic interstitial nephritis
Duration yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
Duration yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical tests
(Signed) E. A. Field M. D.
Oct. 5, 1929 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kendrick	Oct. 6 1929
20. Undertaker	Address
John J. Packard	Troy, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 12 1929

PLACE OF DEATH

County of Latah

City of ~~[illegible]~~ Genesee

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 62

Primary Registration District No. 2142

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68000

Local Registrar's No. 2

2. FULL NAME Nellie Mary Haymond

(a) Residence. No. ..... St. 49
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: A.A. Haymond

6. DATE OF BIRTH (month, day and year): Dec. 11, 1869

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	8	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Bathers New Brunswick Canada

PARENTS

10. NAME OF FATHER: Patrick Cunningham

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mary Driscoll

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant: H.A. Haymond H.A. Haymond

(Address): Genesee, Idaho

15. Filed 7-23, 1929 L.W. Eheus Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22nd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4th, 1929, to Aug 22nd, 1929 that I last saw her alive on Aug 21, 19.. and that death occurred, on the date stated above, at 6:30 A.m.

The CAUSE OF DEATH* was as follows:

Hemmorrhage from Obstruction Jaundice

..... (duration) ..... yrs. 2 mos. 24 ds.

CONTRIBUTORY (Secondary): Carcinoma Duodenal

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb 18th/29

Was there an autopsy? No

What test confirmed diagnosis? Blood & X ray

(Signed) D C Carrasow, M. D.

Aug 22nd, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation~~, or Removal: Moscow Ida. Date of Burial: 8/24 1929

20. Undertaker: H. R. Short Address: Moscow

RECEIVED OCT 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68001

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 3145
Local Registrar's No.
(No. Western Hospital association Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wanda Penford

(a) Residence. No. 14 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ...nford

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 23 | Months 7 | Days 29 | If LESS than 1 day, ...hrs. or ...min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Near Palouse Washington

PARENTS

10. NAME OF FATHER Charles Febold
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Martha Adams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon

14. Informant Charles Febold
(Address) Palouse Washington

15. Filed Oct 17th, 1929. J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1929, to Oct 13, 1929
that I last saw her alive on Oct 13th 1929
and that death occurred, on the date stated above, at 1130 P m.
The CAUSE OF DEATH* was as follows:

Eclampsia
(duration) ...yrs. ...mos. 1 ds.
CONTRIBUTORY (Secondary) Pregnancy.
(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. Hamcher M. D.
Oct. 17th, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Palouse Wash. | Date of Burial: Oct 16 1929
20. Undertaker: E. M. Isaacs | Address: Palouse Wash.

MARGIN RESERVED FOR ___DING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M, 1-16-19

RECEIVED OCT 16 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41

Primary Registration District No. 2/16

(No. ....., ... St.)

File No. 68002

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Venice Arlu Beck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Oct. (Month) 2" (Day) 1929 (Year)

7. AGE .....Yrs.....Mos. 3 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Lorin J. Beck

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Vernie Beasley

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Vernie Beasley

(Address) Salmon, Ida

15. Filed Oct 10 1929 Clio Bellamy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 5 (Day) 1929 (Year) 161a

17. I HEREBY CERTIFY, That I attended deceased from Oct. 8 1929, to Oct 5 1929 that I last saw her alive on Oct 5 1929 and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows: Inanition result of prematurity. Born at 6th mo. of pregnancy

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs.....mos.....ds.

(Signed) [signature] M. D.

Oct 7 1929 (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 3 days In the State.....yrs.....mos. 3 days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Salmon, Ida

DATE OF BURIAL Oct 6 1929

20. UNDERTAKER J. H. Rose

ADDRESS Salmon Ida

SYMS - YORK CO., PTRS. & SORS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 16 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 68003

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41

Primary Registration District No. 2116

(No. ....., ... St.)

2. FULL NAME Venice Elsie Beck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 2" (Day) 1929 (Year)

7. AGE ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Lorin J. Beck

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Vernie Beasley

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. T. Stratton M.D.

(Address) Salmon Idaho

15. Filed Oct 10 1929 Cho Bellamy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 4 (Day) 1929 (Year) 161a

17. I HEREBY CERTIFY, That I attended deceased from Oct. 2 1929, to Oct. 4 1929, that I last saw her alive on Oct 4" 1929, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows: Inanition result of premature, soon about 6th mo. of pregnancy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Oct. 1929 (Signed) O. T. Stratton M. D.

(Address) Salmon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. 2 days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon, Ida

DATE OF BURIAL: Oct 6 1929

20. UNDERTAKER: J. C. Rose

ADDRESS: Salmon, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 24854

RECEIVED OCT 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68004

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Horace Winfield Soule 119

(a) Residence. No. Salmon Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Jane Soule

6. DATE OF BIRTH (month, day and year) Oct. 27, 1851

7. AGE: Years 77, Months 10, Days 17. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fairfield, Maine

PARENTS
10. NAME OF FATHER George A. Soule
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine.
12. MAIDEN NAME OF MOTHER Carolyn Taylor.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maine

14. Informant Kester T. Soule
(Address) Baker, Idaho

15. Filed Oct 10, 1929 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 13th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6th, 1929, to Sept. 13, 1929
that I last saw him alive on Sept. 13th, 1929
and that death occurred, on the date stated above, at 6-30 P m.
The CAUSE OF DEATH* was as follows:
acute ileo-colitis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Objective symptoms
(Signed) O. Stratton, M. D.
Sept. 17, 1929 (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery — Date of Burial: Sept 17th 1929

20. Undertaker: Wm C Doehler — Address: Salmon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 16 1929

PLACE OF DEATH

County of Lemhi

City of Salmon

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 41

Primary Registration District No. 2116

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68005

Local Registrar's No. .....

2. FULL NAME Clarence Kearney Coffman

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

48 B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6. DATE OF BIRTH (month, day and year) Dec 12 - 1874

7. AGE Years 54 Months 9 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) San Francisco Cal

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant General Hospital
(Address) Salmon Idaho

15. Filed Oct 10, 1929 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 6th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1929, to Sept 6, 1929 that I last saw him alive on Sept 6, 19.. and that death occurred, on the date stated above, at 7 20 p. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Several years (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asthma about 2 years (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Chas F Hammer, M. D.

Sept 20, 1929 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salmon Cemetery — Date of Burial 9/7/1929

20. Undertaker Wm C Tolbles — Address Salmon, Ida.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 8 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 47
Primary Registration District No.
File No. 68006
Registered No. 1115

County of Lewis
City of Nezperce State
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Kenick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: About 33 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rober + Holdup Man
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Leslie Brown
(Address) Nezperce Idaho

15. Filed Nov 11 1929 Albert Huff Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 143
Sept (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
6 pistol shots in breast
+ Leg Rober + Holdup man
Killed by Deputy Sheriff
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Albert Huff Coroner M. D.
19... (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nezperce Cemetery
DATE OF BURIAL: Sept 13 1929

20. UNDERTAKER: Albert Huff
ADDRESS: Nezperce Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68007

PLACE OF DEATH
County of Madison
City of Sugar City

Registration District No. 100
Primary Registration District No. 2178
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 74

2. FULL NAME Myron J. Garner

(a) Residence. No. St. 41
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 15 - 1922

7. AGE Years 6 Months 11 Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sugar City

PARENTS

10. NAME OF FATHER Lyman J. Garner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden Utah
12. MAIDEN NAME OF MOTHER Bertha Crandall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vernal Utah

14. Informant Lyman Garner
(Address) Sugar City Ida.

15. Filed 10/31, 1929 J Wyong Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26, 1929, to Oct 28, 1929
that I last saw him alive on Oct 27, 1929
and that death occurred, on the date stated above, at 10 am m.
The CAUSE OF DEATH* was as follows:
Septicemia
Staphylococcus
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) abscess of foot
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? Race of death
Did an operation precede death? no Date of ✓
Was there an autopsy? No. P.M. Examination of pus.
What test confirmed diagnosis? Laboratory findings & symptoms
(Signed) Louis F. Rich, M. D.
10 - 31, 1929 (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sugar City Ida. Date of Burial: Oct. 31 1929.

20. Undertaker: Vern J. Riller Address: Rexburg

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH NOV 9 1929

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

2. FULL NAME Ernest Ellsworth 90

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68008

Local Registrar's No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: June (Month) 11 (Day) 1901 (Year)

7. AGE: 17 Yrs. 4 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF Father: Jerome Ellsworth

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Anne Mary Klingler

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anne Mary Ellsworth

(Address) Rexburg Idaho

15. Filed 10/19 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10th 1929, to Oct 17 1929, that I last saw h/M alive on Oct 17 1929, and that death occurred on the date stated above, at 4:30 P M.

The CAUSE OF DEATH* was as follows:

Dilatation of heart

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

10/18 1929 (Signed) Lorin A Rich M. D.

(Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Annis

DATE OF BURIAL: 10/19 1929

20. UNDERTAKER: [signature]

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68009

Local Registrar's No. 73

1. PLACE OF DEATH

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 222

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wesley Cornell Watson 162

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Infant

6. DATE OF BIRTH

Oct. 13 (Month) (Day) 1929 (Year)

7. AGE

..... Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rexburg Idaho

10. NAME OF Father Cyral Watson

11. BIRTHPLACE OF FATHER (State or Country) Lewiston Utah

12. MAIDEN NAME OF MOTHER Minnie Christensen

13. BIRTHPLACE OF MOTHER (State or Country) Afton Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cyral Watson

(Address) Rexburg Idaho

15. Oct

Filed 18 1929 Wyoming

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 13 1929, to Oct 16 1929, that I last saw him alive on Oct 15 1929, and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(Foetal Heart disease)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Oct 1929 (Address) Rexburg Ida

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rexburg

DATE OF BURIAL Oct. 17 1929

20. UNDERTAKER A B Eckersell

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68010

PLACE OF DEATH
County of Madison
City of Glano

Registration District No. 100
Primary Registration District No. 2178
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 71

2. FULL NAME Fritz Emile Perrenoud. 74A

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If ~~married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Laura Ladil Perrenoud

6. DATE OF BIRTH (month, day and year) Sept 2 — 1857.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	1	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Switzerland.

PARENTS

10. NAME OF FATHER Werther Perrenoud.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Emilie Rouge.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland.

14. Informant Leslie Perrenoud
(Address) Rexburg Rt 3

15. Filed 10/17, 1929 J Rymmo Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1928, to Oct 8, 1929, that I last saw him alive on Oct 7 1929 and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:
Cardio. vascular - renal disease.
Cerebral hemorrhage - Oct - 1928.
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Nephritis, interstitial
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms & Laboratory findings
(Signed) Louis F Rich M. D.
10 - 11, 1929 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Glano Cem. Ida.	Oct 12 1929
20. Undertaker	Address
Leon L. Keller	Rexburg.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH OCT 17 1929

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68011

Local Registrar's No. 70

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry George Maher

188e

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Divorced (Write the word)

6. DATE OF BIRTH: Dec. (Month) 11 (Day) 1876 (Year)

7. AGE: 52 Yrs. 9 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF Father: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Maher

(Address) Oakland California

15. Filed 10/11 1929 J. Rigoning Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1929, to Oct 7 1929, that I last saw him alive on Oct 7 1929, and that death occurred on the date stated above, at 10:20 P M.

The CAUSE OF DEATH* was as follows:

Basal fracture of Skull
Fracture of cervical vertebra

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) Automobile wreck

(Duration) ..... yrs. ..... mos. ..... ds.

10/10 1929 (Signed) Lorin F. Rich M. D.

(Address) Rexburg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ririe Idaho

DATE OF BURIAL: 10/11 1929

20. UNDERTAKER: A B Eckersell

ADDRESS: Rexburg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68012

PLACE OF DEATH

County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 69

2. FULL NAME John X. Anderson

(a) Residence. No. 74A St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma E. Moreton

6. DATE OF BIRTH (month, day and year) April 5, 1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	5	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Grain Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Hyrum, Utah

PARENTS

10. NAME OF FATHER Peter N. Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Caroline Jeppson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Emma E. Anderson
(Address) Rexburg Idaho

15. Filed 10/21, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1929, to Oct 2, 1929
that I last saw him alive on Oct 1st, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
Chronic nephritis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Farley Nelson M. D.
Oct 2, 1929 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg Cemetery	10/3 1929
20. Undertaker	Address
A B Eckersell	Rexburg

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 17 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Madison

City of Plano

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

State File No. 68013

Local Registrar's No. 68

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Johanna Leatham 90

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6. DATE OF BIRTH: March (Month) 10 (Day) 1852 (Year)

7. AGE: 47 Yrs. 6 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hirum Utah

10. NAME OF Father: Rassmus Jensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Mary Swensen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Leatham

(Address) Rexburg RFD # 3

15. Filed 9/25 1929 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1921, to June 20 1921, that I last saw h er alive on June 20 1921, and that death occurred on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart.?
Supposed.
From symptoms—
No doctor has been in attendance
during (Duration) last eight years.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lorin F Rich M. D.

9/24 1929 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? Place of death
Former or usual residence Same.

19. PLACE OF BURIAL OR REMOVAL: Rexburg Cemetery — DATE OF BURIAL: 9/23 1929

20. UNDERTAKER: A B Eckersell — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68014

PLACE OF DEATH
County of Madison
City of Rigby

Registration District No. 100
Primary Registration District No. 2178

Local Registrar's No. 67

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nettie Amelia Stalker. 46

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ WIFE of J. B. Stalker.

6. DATE OF BIRTH (month, day and year) Oct 13 - 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	11	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mt Pleasant Ut

PARENTS

10. NAME OF FATHER Hyrum Sudgen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake Utah
12. MAIDEN NAME OF MOTHER Mary Emily Goldsborough
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salt Lake

14. Informant J. B. Stalker.
(Address) Rigby Idaho

15. Filed 9/20, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October, 1928, to Sept 17, 1929
that I last saw her alive on Sept 17 1929
and that death occurred, on the date stated above, at 845 P. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Anemia
(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? Rest of death
Did an operation precede death? 1928 Date of Oct 5-1928
Was there an autopsy? No
What test confirmed diagnosis? Laboratory & Clinical findings
(Signed) Vern J. Keller, M. D.
9-19-, 1929 (Address) Teton Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ashton Ida.	Sept 20-1929.

20. Undertaker	Address
Vern J Keller	Rigby.

RECEIVED OCT 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68015

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 66

126

2. FULL NAME Virginia Nielson
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) December 12-1925

7. AGE: Years 3, Months 10, Days 4. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): St. Anthony Idaho.

PARENTS
10. NAME OF FATHER: Fred L. Nielson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Washington
12. MAIDEN NAME OF MOTHER: Ora Baum
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Fred L. Nielson
(Address) St. Anthony Idaho

15. Filed 9/17, 1929 J. Kyoung Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 16 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15th, 1929, to Sept. 16, 1929
that I last saw her alive on Sept. 16, 1929
and that death occurred, on the date stated above, at 3:30 P.m.
The CAUSE OF DEATH* was as follows:
Acute Peritonitis
..... (duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Acute Appendicitis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of 9-16-29
Was there an autopsy? no
What test confirmed diagnosis? Operation
(Signed) P. M. Kelly, M. D.
9-16-, 1929 (Address) St. Anthony, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashton
Date of Burial: 9/18 1929

20. Undertaker: W. M. Hansen Address St. Anthony Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68016

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 52

31

2. FULL NAME Ellie Jane Humphries

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 18 1869

7. AGE Years 60 Months 6 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10. NAME OF FATHER Sterling Tingen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina
12. MAIDEN NAME OF MOTHER Ellen Duncan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14. Informant Lewis R Humphries
(Address) Rupert Ida

15. Filed Oct. 18, 1929 E H Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 13 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 18, 1929, to Oct 18, 1929
that I last saw her alive on Oct 3, 1929
and that death occurred, on the date stated above, at 8.30 A m.
The CAUSE OF DEATH* was as follows:
Tuberculosis, Pulmonary
Bilateral
about
(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Leland Forgin, M. D.
....., 19..... (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rupert Ida
Date of Burial Oct. 16 19

20. Undertaker D. E. Johnson
Address Burley

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68017

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
Local Registrar's No. 57

(No.) 164
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Trassa Ann Vail

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 23 1844

7. AGE — Years: 85 | Months: 11 | Days: 26 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10. NAME OF FATHER: Jacob Belar
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Sarah Jane Cragen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Elvira Livingston
(Address) Rupert Idaho.

15. Filed Oct. 20, 1929 E. H. Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 9.30 A m.
The CAUSE OF DEATH* was as follows:

Senility
No Doctor Called
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. J. Goodman Coroner, M. D.
, 19 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Thayne Wyo
Date of Burial: Oct. 21 19

20. Undertaker: D. E. JOHNSON
Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68018

PLACE OF DEATH
County of Minidoka
City of Rupert
Registration District No. 19
Primary Registration District No. 2015
(No.)
Local Registrar's No. 50

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Robert Hall

(a) Residence. No. 94 St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 16 | Months 10 | Days | If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Utah

PARENTS
10 NAME OF FATHER: J. A. Hall
11 BIRTHPLACE OF FATHER (city or town) (State or country): Utah
12 MAIDEN NAME OF MOTHER: Nina M Lee
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Utah

14 Informant: J. A. Hall
(Address): Yost Utah

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 15 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1929, to Oct 15, 1929, that I last saw him alive on Oct 15, 1929, and that death occurred, on the date stated above, at 3 45 m.

The CAUSE OF DEATH* was as follows:
(Cerebrospinal Meningitis)
Meningococcic Meningitis
(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Yost, Utah
Did an operation precede death? no Date of —
Was there an autopsy? no (Spinal fluid)
What test confirmed diagnosis? Microscopic examination
(Signed) Helen Strain, M. D.
10-16, 1929 (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Yost Utah
Date of Burial: Oct 16 1929

20. Undertaker: W. G. Goodman
Address: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68019

PLACE OF DEATH
County of Minidoka
City of Rupert
Registration District No. 19
Primary Registration District No. 2013
(No.)
Local Registrar's No. 42

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Sheldon J Hawkins

(a) Residence. No. 91a St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lizzie A Hawkins

6 DATE OF BIRTH (month, day and year) May 17 1856

7 AGE: Years 73 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Merchant & Grain
(b) General nature of industry, business, or establishment in which employed (or employer): buyer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dover Ohio

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: Lucy Hellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: L. A. Hawkins
(Address): Hollister Idaho

15 Filed 10-14, 1929 E. B. Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 12 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....,
that I last saw h.... alive on ....., 19....,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Ruptured aneurysm of aorta
Death almost instantaneous
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....
Did an operation precede death? ..... Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? .....
(Signed) W B Kenagy, M. D.
Oct 14, 1929 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Wakeman Ohio
Date of Burial: Oct 18 1929

20. Undertaker: W. G. Goodman
Address: Rupert Idaho

FORM V. S. No. 1-19. RECEIVED NOV 8 1929

CERTIFICATE OF DEATH 6

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

File No. 68020

Registered No. 53

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roy J Morgan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 26 (Day) 1893 (Year)

7. AGE: 36 Yrs. 8 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION: Farmer

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: James F Morgan

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Mary J Pittman

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edith Morgan

(Address) Rupert Idaho

15. Filed 10-24 1929 E W Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4

Oct (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30 1929, to Oct. 17 1929, that I last saw him alive on Oct. 16 1929, and that death occurred on the date stated above, at 2:00 A.M.

The CAUSE OF DEATH* was as follows:

Undulant Fever

(Duration) ..... Yrs. ..... mos. 22 ds.

Contributory (Secondary) Diagnosis aided by positive Blood agglutination

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E W Elmore M.D.

11-6 1929 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Heyburn Cemetry

DATE OF BURIAL: Oct 20 1929

20. UNDERTAKER: W. A. Goodman

ADDRESS: Idaho Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

PLACE OF DEATH

County of Nez Perce

City of Lewiston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 95

Primary Registration District No. 1009

(No. White Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68021

Local Registrar's No.

2. FULL NAME Elsie Phylena Jumwalt

(a) Residence. No. Lewiston Orchards St. 161a

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6. DATE OF BIRTH (month, day and year) Oct 1st 1929

7. AGE Years Months Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS

10. NAME OF FATHER C. E. Jumwalt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Washington

12. MAIDEN NAME OF MOTHER Elsie Van Dyke

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant C. E. Jumwalt

(Address) Lewiston Orchards.

15. Filed Nov 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1929, to Oct 3, 1929

that I last saw her alive on Oct 3, 1929

and that death occurred, on the date stated above, at 4a. m.

The CAUSE OF DEATH* was as follows:

Unknown Premature 7 mos.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? History of Case

(Signed) E. L. White, M. D.

80-3, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Cemetery — Date of Burial: Oct 4 1929

20. Undertaker: Vassar's Mortuary — Address: Lewiston

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68122

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clay McNamee
(a) Residence. No. 49 Prospect Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of July 1870

6. DATE OF BIRTH (month, day and year) ~~Oct 13 1854~~

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lawyer.
(b) General nature of industry, business, or establishment in which employed (or employer) Practicing Attorney
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Henry McNamee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) —
12. MAIDEN NAME OF MOTHER Josephine —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Mrs Clay McNamee
(Address) Lewiston

15. Filed Oct 7, 1929 Emma E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1929, to 10-3, 1929 that I last saw h~~im~~ alive on 10-3, 1929 and that death occurred, on the date stated above, at 11 50 A m.

The CAUSE OF DEATH* was as follows:
Angina Pectoris.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis & apoplexy
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E L White, M. D.
10-3, 1929. (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	10/6 1929
20. Undertaker	Address
Vassar Bird	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68023

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1809
(No. White Hospital) 57
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Mike Conway

(a) Residence. No. ..... St. Caldesac
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ✓

PARENTS
10. NAME OF FATHER ✓
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant Records at White Hospital
(Address) Lewiston Idaho.

15. Filed Oct 10, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 2- (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-29- 1929, to 10-2 1929
that I last saw him alive on 10-2-29, 19
and that death occurred, on the date stated above, at 10.30 p.m.
The CAUSE OF DEATH* was as follows:
Diabetes mellitus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs & symptoms.
(Signed) J. H. Barnes M.D. M. D.
10-2-29, 19 (Address) Lewiston Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	Oct 15 1929
20. Undertaker	Address
Vossan Und. Co.	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68024

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Wilfred Corkell

(a) Residence. No. Leland Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

15 B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 39 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED ✓
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) farming
(c) Name of employer

9. BIRTHPLACE (city or town) ✓
(State or country)

PARENTS

10. NAME OF FATHER John Corkell
11. BIRTHPLACE OF FATHER (city or town) ✓
(State or Country)
12. MAIDEN NAME OF MOTHER Anna Cotters
13. BIRTHPLACE OF MOTHER (city or town) ✓
(State or Country)

14. Informant Records at Hospital
(Address)

15. Filed Nov 1, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 5th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29th, 1929, to Oct 5th, 1929
that I last saw him alive on Oct 5th, 1929
and that death occurred, on the date stated above, at 8 15 9 m.
The CAUSE OF DEATH* was as follows:

Lung abscess
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumococcus Infection
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Leland Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Gray chest + Pneumococcus
(Signed) C Clearsdow, M. D.
, 19 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal ✓ Kendrick
Date of Burial 19

20. Undertaker Trickard Co
Address Kendrick Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68025

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Paul Clark Geiselbrecht.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 10/4/29

7. AGE	Years	Months	Days	If LESS than 1 day,
	0			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS

10. NAME OF FATHER J. S. Geiselbrecht
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Marylu Curtis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant J. S. Geiselbrecht
(Address) Lewiston, Idaho

15. Filed Nov 1, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4, 1929, to Oct 9, 1929
that I last saw him alive on Oct 8, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows: Premature Infant (6 mo)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W O Clark M. D.
Oct 9, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	10/10/29
20. Undertaker	Address
Brower-Mann Co	Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

DISINTERMENT PERMIT

RECEIVED
SEP 20 1971
Bureau of Vital Statistics

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Paul Clark Geiselbrecht

now lying buried in Normal Hill Cemetery, in the City or Town of Lewiston

County of NezPerce State of Idaho, who died on the 9th day of October, 1929, Aged Less than 1 day

~~XXXX

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68026

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Henry Lee Church

(a) Residence. No. St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 9/27/1845.

7. AGE Years 84 Months — Days 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Va.

PARENTS
10. NAME OF FATHER Octavious Church
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Merritt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Va.

14. Informant Dr J M Church
(Address) Lewiston Idaho

15. Filed Nov 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 9 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on about 1 yr ago 19
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Acute dilitation of heart
Instant
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis.
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardiac symptoms
(Signed) E. L. White, M. D.
10/10, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Minneapolis, Minn. Date of Burial 19
20. Undertaker Brower-Wann Co Address Lewiston Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68027

Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. .....

PLACE OF DEATH

County of Nez Perce
City of Lewiston

(No. 314) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Loyd Isaac Malcom

(a) Residence. No. ..... St. Anatone Wash
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) May 13 1916

7. AGE	Years	Months	Days	If LESS than 1 day,
	13	4	25	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At school
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Anatone Wash

PARENTS

10. NAME OF FATHER G I Malcom
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Umatilla Oregon
12. MAIDEN NAME OF MOTHER Mable Fields
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lewiston Idaho

14. Informant G I Malcom
(Address) Anatone Wash

15. Filed Oct 10, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6th, 1929, to Oct 8th, 1929, that I last saw h~~im~~ alive on Oct 8th, 1929, and that death occurred, on the date stated above, at 1-30 a.m.

The CAUSE OF DEATH* was as follows:

General Peritonitis
(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Appendix ruptured
(duration) ..... yrs. ..... mos. 6 ds.

18. Where was disease contracted if not at place of death? Anatone Wash
Did an operation precede death? Yes Date of Oct 6/29
Was there an autopsy? No
What test confirmed diagnosis? Laparotomy

(Signed) O C Carsaon, M. D.
10/9, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clarkston Wash	10/10 1929

20. Undertaker	Address
J F R Merchant	Clarkston

Carsaon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68028

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME C. E. Rigdon

(a) Residence. No. Lewiston Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

5-8a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Aug 29 1885

7. AGE: Years 44 | Months 1 | Days 12 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sheepman
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sao County Nebr.

PARENTS
10. NAME OF FATHER: Chas H Rigdon
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kans.
12. MAIDEN NAME OF MOTHER: Eliza Boggs.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Mrs C. P. Ragsdale
(Address) Baker City Oregon

15. Filed Oct 10, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8, 1929, to Oct 10th, 1929
that I last saw him alive on Oct 10th, 1929
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Pernicious Anaemia
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. White, M. D.
10-12, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho | Date of Burial: Oct 13 1929

20. Undertaker: Passar Mortuary Inc. | Address: Lewiston Idaho

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68029

PLACE OF DEATH
County of Nezperce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. White Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 134

2. FULL NAME Alma May Stellman.

(a) Residence. No. 1017 — Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of George Stellman

6. DATE OF BIRTH (month, day and year) 12/11/1907

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	10	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pasadena, California.

PARENTS

10. NAME OF FATHER H. L. Alspach
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Gertrude Casey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant W. L. Alspach
(Address) Lewiston Idaho

15. Filed Nov 1, 1929 Susan E Brue Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 15th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1929, to Oct 15th, 1929
that I last saw her alive on Oct 15th, 1929
and that death occurred, on the date stated above, at 7. P. m.

The CAUSE OF DEATH* was as follows:
Pelvic Abscess
with T. B. Peritonitis.
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Salpingitis of unknown origin
(duration) yrs. 10 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of Oct 13-29
Was there an autopsy? No
What test confirmed diagnosis? Pathology at operation.
(Signed) E. L. White M. D.
10/16, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	10/18 19 29
20. Undertaker	Address
Brower-Adams Co.	Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Carson

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68030

PLACE OF DEATH
County of Nez Perce
City of Lewiston Orchards
Registration District No. 95
Primary Registration District No. 1009
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Cora Bennett

(a) Residence. No. Lewiston Orchards St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 12 - 1885

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	3	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School teacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Geo Kennedy.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER — Thompson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn

14. Informant Lena Bennett
(Address) Lewiston

15. Filed Nov 1, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16, 1929, to Oct 20, 1929
that I last saw her alive on Oct 28, 1929
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease.
(duration) yrs. 9 mos. ds.
CONTRIBUTORY (Secondary) Anasarca
(duration) yrs. 9 mos. ds.
Pul. edema.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Findings
(Signed) Paul G. Henry M. D.
Oct 21, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	Oct 22 1929
20. Undertaker	Address
Vassar Mortuary	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

White

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68021

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

PLACE OF DEATH

County of Nez Perce

City of Lewiston

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alberta B Frye

(a) Residence. No. 1817 15th Ave St. 32

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 24-1923

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	5	11	76	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Walter Frye

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill

12. MAIDEN NAME OF MOTHER Tillie Manning

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant Walter Frye

(Address) 1817 - 15th Ave Lewiston

15. Filed Nov 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1929 to Oct 20, 1929

that I last saw h. alive on Oct 20, 1929

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cardonal Symp.

(Signed) E. L. White, M. D.

10-21, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	10 22 1929
20. Undertaker	Address
Vassar Mortuary	Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68032

PLACE OF DEATH
County of Nez Perce
City of Lewiston Ida
Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Bert Rideout
(a) Residence. No. Clearwater County Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): July 8th 1883
7. AGE: Years 46 | Months 3 | Days 10 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Timber worker.
(b) General nature of industry, business, or establishment in which employed (or employer): Cutting & Logging Timber
(c) Name of employer: Self.
9. BIRTHPLACE (city or town) (State or country): Washington

PARENTS
10. NAME OF FATHER: R. R. Rideout
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Lethie —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant: Mrs B. N. Rosam
(Address): Clarkston Wash
15. Filed Oct-21, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 16, 1929, to Oct 18, 1929
that I last saw h[illegible] alive on Oct 18, 1929
and that death occurred, on the date stated above, at 7 a.m.
The CAUSE OF DEATH* was as follows:
General Septicaemia
Thrown from horse.
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Infection due to injury of face
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. R. White, M. D.
10-21, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	10/19 1929
20. Undertaker: Vassar Mortuary	Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68032

Dr. E.L. White

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Bert Rideout who died at Lewiston, Idaho on Oct. 18, 1929
Cause of death given as "General Septicaemia.""Infective injury of face."

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO WAS INVOLVED, PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Thrown from horse. None

E. L. White

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68033

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 95
Primary Registration District No. 1009
(No.) 31
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Melvin B.
(a) Residence. No. Lewiston Orchards St. [illegible]
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 3/14/1904

7. AGE Years 25 Months 7 Days 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid for several
(b) General nature of industry, business, or establishment in which employed (or employer) Years.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clyde Ohio.

PARENTS
10. NAME OF FATHER James Parker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Concord Kentucky.
12. MAIDEN NAME OF MOTHER Dora Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kokomo Indiana

14. Informant Mrs James Parker
(Address) Lewiston Idaho.

15. Filed Nov 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 18th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-10-29, 19, to 10-18-, 1929
that I last saw him alive on 10-18-29, 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Miliary tuberculosis.
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs & symptoms
(Signed) H. Rankin M.D., M. D.
10/18, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 10/20 1929

20. Undertaker Brower - Dawn E Lewiston Idaho
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68034

PLACE OF DEATH

County of Nezperce

City of Lewiston Ida

Registration District No. 96

Primary Registration District No. 1009

(No. St Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101 B

2. FULL NAME Sarah Elizabeth Carpenter

(a) Residence. No. Farmington Wash St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of S.J. Carpenter

6. DATE OF BIRTH (month, day and year) Sept 24, 1862

7. AGE Years 67 Months Days 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bone County, Ill.

PARENTS

10. NAME OF FATHER George Fowler

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known

12. MAIDEN NAME OF MOTHER Lenox

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Q.A. Kaune
(Address) Everett, Wash.

15. Filed Oct 18, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1929, to Oct 17, 1929

that I last saw her alive on Oct 17, 1929

and that death occurred, on the date stated above, at 11 15 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diag

(Signed) L B Stockslager M. D.

10/18, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Eugene, Ore. Date of Burial 19

20. Undertaker H.R. Merchant Address Clarkston Wn

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68035

PLACE OF DEATH

County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Walter S. McDowell
(a) Residence. No. ..... St. near Gifford Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): 12/13/1881
7. AGE: Years 47, Months 10, Days 8. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Minnesota

PARENTS
10. NAME OF FATHER: G. C. McDowell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N.Y.
12. MAIDEN NAME OF MOTHER: Mary Hills
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wisconsin

14. Informant: Mrs Geo. S. Glasby
(Address) Spalding, Idaho.

15. Filed Nov 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 21st (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21, 1929, to Oct 21, 1929
that I last saw him alive on Oct 21st, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Shock
Struck by No. Pacific train in auto
(duration) ..... yrs. ..... mos. — ds.
CONTRIBUTORY (Secondary) Compound fracture 3rd Lumber & Fracture 4th Lumber
(duration) ..... yrs. ..... mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Palpation
(Signed) O. C. Carlson M. D.
10/24, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho
Date of Burial: 10/24 1929
20. Undertaker: Brower - Warm Co
Address: Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68035

Dr. O.C. Carssow
Lewiston

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Walter S. McDowenn who died at Lewiston, Idaho on Oct. 21, 1929
Cause of death given as "Shock."
Contributory given as "Compound fracture 3rd lumbar & fracture 4th lumbar."

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH . IF DUE TO AUTO PLEASE STATE WHERE THE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

This man was struck by Northern Pacific Passenger Motor car at Spalding or Joseph Idaho crossing while driving his automobile

O. C. Carssow M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

PLACE OF DEATH

County of Nez Perce

City of Near Lewiston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68036

Registration District No. 95

Primary Registration District No. 1009

Local Registrar's No.

(No.) 170

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Willie W. Eggers

(a) Residence. No. St. Orchards

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 2/3/1895

7. AGE Years 34 Months 8 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Horticulturist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pendleton Oregon

PARENTS

10. NAME OF FATHER Geo. D. Eggers

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Louise Bader

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs Carol Eggers

(Address) Lewiston, Idaho

15. Filed Nov 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at about 8:30 A.m.

The CAUSE OF DEATH* was as follows: Gunshot Wound in Head Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Em Brown Coroner, M. D.

10/26, 1929 (Address) Lewiston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho. Date of Burial 10/28 1929

20. Undertaker Brown-Wann Co Address Lewiston Idaho

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68037

PLACE OF DEATH

County of Nez Perce

City of 6 miles East of Juliaetta

Registration District No. 95

Primary Registration District No. 1009

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cass F. Hulbert

(a) Residence. No. St. 101a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 64 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Trapper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Birmingham
(State or country) Michigan

PARENTS

10. NAME OF FATHER George Hulbert

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Unknown

14. Informant L B Wann
(Address) Lewiston Idaho

15. Filed Nov 1, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21, 1929, to Oct 23, 1929
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 1:15 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac irregularity Prob - Myocarditis unknown (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. H. Field, M. D.

Oct. 25, 1929 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston, Idaho | Date of Burial 10/29 1929

20. Undertaker Brower-Wann Co. | Address Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68038

PLACE OF DEATH
County of Nez Perce
City of 11 mile S.E. of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Richard Greer

(a) Residence. No. 22 [illegible] St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Greer

6. DATE OF BIRTH (month, day and year) 7/23/1886

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	3	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer - Cook -
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Grace Greer
(Address) Stellicoom, Wash

15. Filed Nov 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at about 10:30 A.M.
The CAUSE OF DEATH* was as follows:
Fractured Skull
Auto Accident
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [illegible] Coroner. M. D.
10/27, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	10/31 1929
20. Undertaker	Address
Brown - Warnick	Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68039

PLACE OF DEATH
County of Nez Perce
City of Near Lewiston

Registration District No. 95
Primary Registration District No. 1009
Local Registrar's No.
(No. 1486)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Merle McNamee

(a) Residence. No. 302 — 1st Avenue. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 4/8/1896

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
33	6	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Assistant Saw Filer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Clearwater Timber Co.

9. BIRTHPLACE (city or town) Moscow
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Clay McNamee
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Mo.
12. MAIDEN NAME OF MOTHER Effie Leasure
13. BIRTHPLACE OF MOTHER (city or town) Eugene
(State or Country) Oregon

14. Informant Mrs Muriel McNamee
(Address) Lewiston Idaho.

15. Filed Nov 1, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 27th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at about 1:50 A m.
The CAUSE OF DEATH* was as follows:
Fracture of Skull
Due to accident.
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Earl Brower Coroner
10/27, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	10/29, 1929

20. Undertaker Brower-Warn Co. Address Lewiston, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Carsson

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68040

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

153

2. FULL NAME Frank Beyer

(a) Residence. No. St. Kendrick Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 3/14/1913

7. AGE 16 Years Months 7 Days 16 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dearey Idaho

PARENTS
10. NAME OF FATHER Chas. S. Beyer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mamie Casten
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Chris Beyer
(Address) Kendrick, Idaho.

15. Filed Nov 1, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30th, 1929, to Oct 30th, 1929
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Lung Abscesses
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Punctured lung from injury autoaccident
(duration) yrs. mos. 31 ds.

18. Where was disease contracted if not at place of death? Kendrick Idaho
Did an operation precede death? No Date of
Was there an autopsy? None
What test confirmed diagnosis? Pus pumped from lung
(Signed) O. C. Carsson, M. D.
10/31, 1929 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Near Kendrick Idaho
Date of Burial Nov 1st 1929

20. Undertaker Brower-Wann Co.
Address Lewiston, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68041

PLACE OF DEATH

County of Nezperce
City of Kendrick

CERTIFICATE OF DEATH

Registration District No. 63
Primary Registration District No.
(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. **FULL NAME** Lulu May Janes

(a) Residence. No. Kendrick St. 164
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female
4 COLOR OR RACE: white
5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): married

5a If married, ~~widowed~~, or ~~divorced~~ ~~[illegible]~~ (or) WIFE of Arthur Eugene Janes

6 DATE OF BIRTH (month, day and year) March 16 - 1873

7 AGE: Years 56 | Months 6 | Days 14 | If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carrollton Illinois

PARENTS
10 NAME OF FATHER: George W. Garrelts
11 BIRTHPLACE OF FATHER (city or town) (State or country): Norden Germany
12 MAIDEN NAME OF MOTHER: Louesa Fisher Lulu May J Garrelts
13 BIRTHPLACE OF MOTHER (city or town) (State or country): York, Pa.

14 Informant: A. E. Janes
(Address) Kendrick Idaho

15 Filed Oct 7, 1929 B. F. Nesbit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 5th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ___, 19___, to ___, 19___, that I last saw h___ alive on ___, 19___, and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows: Suicide - Strangulation by Hanging by neck

Cause of suicide (duration) ___ yrs. ___ mos. ___ ds.

~~CONTRIBUTORY~~ (Secondary) Melancholia

cause of melancholia (duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? Structure of colon

Did an operation precede death? ___ Date of Dr. E. H. Field Kendrick

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Ellis Brown Coroner, M. D.

Oct 7, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: John J Pickerd
Date of Burial: Oct 9 1929

20 Undertaker: Kendrick
Address: Troy Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68042

PLACE OF DEATH
County of Nezperce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1089
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74A

2. FULL NAME Fred Crouse

(a) Residence. No. Lewiston Orchards St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Apr. 10 1894

7. AGE: Years 35 | Months 5 | Days 3 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10. NAME OF FATHER: Josiah Crouse
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. C.
12. MAIDEN NAME OF MOTHER: Louise Parsons
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N. C.

14. Informant: Mrs Ruby Nelson
(Address): Lewiston Orchards.

15. Filed Sept. 30, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1929, to Sept 13, 1929
that I last saw h~~im~~ alive on Sept 13, 1929
and that death occurred, on the date stated above, at 4:40 A m.
The CAUSE OF DEATH was as follows:
Apoplexy.
(duration) 4 hours. yrs. mos. ds.
CONTRIBUTORY (Secondary) Nephritis
several years.
(duration) yrs mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Paul W Johnson, M. D.
9/14, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho — Date of Burial 9/15 1929
20. Undertaker: Casar Mortuary Inc. — Address Lewiston Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68043

PLACE OF DEATH

County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Chas. B. Batten
(a) Residence. No. 917 10th Ave. St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Batten

6. DATE OF BIRTH (month, day and year): March 3 1854

7. AGE: Years 75, Months 6, Days 19. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Special Agent
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Northern Pacific R.R.

9. BIRTHPLACE (city or town) (State or country):

PARENTS

10. NAME OF FATHER: Thos. Batten
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Elizabeth Ellis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Mrs Mary Batten
(Address) Lewiston Idaho

15. Filed Sept-30, 1929. Susan E Bruce, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 22nd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20th, 1929, to September 22nd, 1929 that I last saw him alive on September 22nd, 1929 and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis
(duration) + yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary): Age - unable to urinate - had sclerated prostate - could not use catheter without giving anaesthetic - prostatic uretha practically closed
(duration) yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 22nd 29 a cystostomy

Was there an autopsy? No

What test confirmed diagnosis? Age pulse etc

(Signed) O C Carsson, M. D.
, 19__ (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho
Date of Burial: Sept-22 1929

20. Undertaker: Vassar Mortuary Inc.
Address: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 5 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68043

Dr. O.C. Carssow
Lewiston
Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Chas. B. Batten who died at Lewiston, Idaho on Sept. 22, 1929
Cause of death given as "Arteriosclerosis."

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Unable to urinate had sclerotic prostate could not use catheter without giving anaesthetic prostatic urethra practically closed

RECEIVED OCT 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68044

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Stewart W Whitford

(a) Residence. No. 140 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 2/10/1863

7. AGE	Years	Months	Days	If LESS than 1 day,
	66	7	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Orchardist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10. NAME OF FATHER S. Whitford
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Annie Arstcott
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs S. W. Whitford
(Address) Lewiston Idaho

15. Filed Sept 30, 1929 Susan E Brun
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 21st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4th, 1929, to Sept 21st, 1929
that I last saw h alive on Sept 21st, 1929
and that death occurred, on the date stated above, at 11:45 P m.
The CAUSE OF DEATH* was as follows:

Hemmorhage from Obstruction
(duration) yrs. mos. 28 ds.
CONTRIBUTORY (Secondary) Cancer of Stomach
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X Ray + Symptoms

(Signed) O G Carpenter, M. D.
9/21, 1929 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho. Date of Burial: 9/24 1929
20. Undertaker: Brown-Wann Co. Address: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68045

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

183

2. FULL NAME Frank L. Brown

(a) Residence. No. St. Craigmont, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 4/21/1868

7. AGE 61 Years Months 4 Days 27 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Deputy Sheriff
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Lewis Co., Idaho.

9. BIRTHPLACE (city or town) (State or country) Montana

PARENTS
10. NAME OF FATHER Frank G. Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Jardel J. Bowman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Boston, Mass.

14. Informant Mrs F. L. Brown
(Address) [illegible]

15. Filed Sept-30, 1929 Susan E Brus Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 18th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-12-29, 19, to 9-18-, 1929
that I last saw him alive on 9-18-29, 19
and that death occurred, on the date stated above, at 1:15 A.m.
The CAUSE OF DEATH* was as follows:
Gun shot wound through stomach and abdomen.
Shot while making an arrest
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 9-12-29
Was there an autopsy? No
What test confirmed diagnosis? Signs & symptoms
(Signed) H. Rogers M.D. M. D.
9/21, 1929 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 9 1929

20. Undertaker Brown-Wann Co
Address Lewiston Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 5 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68045

Dr. H. Rouse
Lewiston

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Frank L. Brown who died at Lewiston, Idaho on Sept. 18, 1929
Cause of death given as "Gunshot wound through stomach and abdomen."

Information DESIRED in order to complete certificate:

WAS DEATH DUE TO SUICIDE, HOMICIDE OR ACCIDENT.?

PLEASE ANSWER BELOW:

Shot while making an arrest.

H. Rouse. M.D.

RECEIVED OCT 24 1929

Lyle.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68046

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 10
Local Registrar's No.
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert C. Hardman.

(a) Residence. No. 2213 8th, Avenue. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 18th, 1860.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69.	6.	24.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER ------- Hardman.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.
12. MAIDEN NAME OF MOTHER ------ Calvert.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant Owen Hardman
(Address) Peck, Idaho.

15. Filed Sept-12, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 12th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4, 1929 to Sept 12, 1929
that I last saw him alive on Sept 12, 1929
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH was as follows:
Encephalitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. M. Lyle, M. D.
9/12/29, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Peck, Idaho.	9/14/15 19 29
20. Undertaker	**Address**
Brower-Mann Company.	Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68047

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. St. Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

120

2. FULL NAME Henry J. Herman Jr.

(a) Residence. No. St. Genesee, Ida.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Herman

6. DATE OF BIRTH (month, day and year) Sept 21, 1889

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
39	11	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Uniontown Wash.

PARENTS

10. NAME OF FATHER: Henry J. Herman

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known Iowa

12. MAIDEN NAME OF MOTHER: Mary Scharnhorst

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: Mrs. Mary Herman
(Address) Genesee, Idaho

15. Filed Sept 30, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 12, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to Sept 12, 1929 that I last saw him alive on Sept 12, 1929 and that death occurred, on the date stated above, at 8 25 P m.

The CAUSE OF DEATH* was as follows:

General Toxemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Peritonitis General acute (duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? Genesee Idaho

Did an operation precede death? yes Date of Sept 11 1929

Was there an autopsy? no

What test confirmed diagnosis? High Leucocyte count

(Signed) E G Braddock, M. D.

Sept 17, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Genesee, Ida.

Date of Burial: 9-16 1929

20. Undertaker: H. R. Short

Address: Moscow, Ida

White

RECEIVED OCT 24 1929

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68048

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. 1321 Idaho Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Alfred Gehrke.

(a) Residence. No. 1321 Idaho Street. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 10th, 1869.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60.	8.	1.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Knox County, Missouri.

PARENTS

10. NAME OF FATHER Zachariah Gehrke.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hanover, Germany.

12. MAIDEN NAME OF MOTHER Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Mrs J. A. Gehrke.
(Address) Lewiston, Idaho.

15. Filed Sept-30, 1929 Susan E Brun
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 11th, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug-10, 1929, to Sept 11th, 1929
that I last saw him alive on Sept 1st, 1929
and that death occurred, on the date stated above, at 5-30 A m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory and Cardinal Symptoms Findings

(Signed) E. L. White, M. D.

9/11/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	9/13/29. 19

20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 24 1929

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

(No. 1017 Idaho Street.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

White

DO NOT WRITE IN THIS SPACE

State File No. 68049

Local Registrar's No.

1612

2. FULL NAME Jean Stellman.

(a) Residence. No. 1017 Idaho Street. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 9/10/1929.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
------.	-----.	1.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston,
(State or country) Idaho.

PARENTS

10. NAME OF FATHER George Stellman.

11. BIRTHPLACE OF FATHER (city or town) Nez Perce,
(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Alma Alspach.

13. BIRTHPLACE OF MOTHER (city or town) Pasadena,
(State or Country) California.

14. Informant George Stellman

(Address) Lewiston, Idaho.

15. Filed Sept-30, 1929 Susan E Bunn
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 11th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to Sept 11, 1929,
that I last saw h alive on Sept 11, 1929
and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Prematue - 7½ month
Cause unknown.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Family history.

(Signed) E. L. White, M. D.

9/11/29, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nez Perce, Idaho.	9/11/29. 19
20. Undertaker	**Address**
Brower-Vann Company.	Lewiston, Idaho.

RECEIVED OCT 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Johnson.

DO NOT WRITE IN THIS SPACE
State File No. 68050

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME James Orville Pate.

(a) Residence. No. St. Kooskia, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Divorced.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 4/8/1886.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43.	5.	1.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas.

PARENTS

10. NAME OF FATHER Bird Pate.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois.
12. MAIDEN NAME OF MOTHER Clara Venta.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana.

14. Informant Mrs L. M. Bowman.
(Address) Lewiston, Idaho.

15. Filed Sept-12, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
September 9th, 1929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from
Sept 2, 1929, to Sept 9, 1929
that I last saw him alive on Sept 8, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Organic heart disease
(duration) Several years yrs. mos. ds.
CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Ruth Johnson, M. D.
9/11/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	9/11/29. 19
20. Undertaker	**Address**
Brower-Jann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Braddock

RECEIVED OCT 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68051

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 95

Primary Registration District No. 1009

Local Registrar's No.

(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rudderick Carlton Miller.

(a) Residence. No. St. Genessee, Idaho. 131
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 4/11/1868.

7. AGE: Years 61. Months 4. Days 26. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wisconsin.

PARENTS

10. NAME OF FATHER: Tennis E. Miller.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Anna Atherson.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway.

14. Informant: Lee W. H. Miller
(Address) Genesee, Idaho.

15. Filed Sept-12, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 7th, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Sept 7, 1929
that I last saw him alive on Sept 7, 1929
and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Uremia et arterio Sclerosis General
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy Prostate with Retention (duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? Genesee Idaho

Did an operation precede death? yes Date of Aug 20 1929

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) E G Braddock, M. D.
9/10/29. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Genesee, Idaho. Date of Burial: 9/11/29. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68052

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.

PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1006

2. FULL NAME Alvin Wappler
(a) Residence. No. 1218 Eighth Lane St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Malvina Wappler.
6. DATE OF BIRTH (month, day and year): March 2 1889
7. AGE: Years 40 | Months 7 | Days 5 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: mill worker.
(b) General nature of industry, business, or establishment in which employed (or employer): Box factory
(c) Name of employer: Clearwater Lumber Co.
9. BIRTHPLACE (city or town) (State or country): Ind.

PARENTS
10. NAME OF FATHER: Oscar Wappler.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.
12. MAIDEN NAME OF MOTHER: Ida
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Mrs A. Wappler
(Address): Lewiston Idaho

15. Filed Sept 13, 1929 Susan E Brune Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1929, to Sept 7, 1929
that I last saw h~~im~~ alive on Sept 7, 1929
and that death occurred, on the date stated above, at 9:40 P. m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia.

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary): Acute myocarditis
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Ralph M. Allen M. D.
Sept 10, 1929 (Address) Lewiston Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
San Francisco Calif	19
20. Undertaker: Vassar Mortuary Inc	Address: Lewiston Idaho

Brad[illegible]ck

RECEIVED OCT 24 1929

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68053

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

41

2. FULL NAME Samuel S. Williams.

(a) Residence. No. St. Kamiah, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Widower.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Elsie Williams.

6. DATE OF BIRTH (month, day and year): 11/7/1891.

7. AGE: Years 37. Months 10. Days -0-. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Almena, Kansas.

PARENTS

10. NAME OF FATHER: Not known.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known.

12. MAIDEN NAME OF MOTHER: Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known.

14. Informant: T. Davis.
(Address) Kamiah, Idaho.

15. Filed Sept 12, 1929 Susan E. Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 7th, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3, 1929, to Sept 7, 1929
that I last saw him alive on Sept 7, 1929
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:

Septic Infection

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Comp Fracture L Forearm - auto wreck over grade near Kamiah, Idaho.
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? Kamiah Idaho

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood culture

(Signed) E. G. Brodock, M. D.

9/10/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 9/11/29. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 - 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68053

Dr. E.G. Braddock
Lewiston

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Samuel S. Williams who died at Lewiston, Idaho on Sept. 7, 1929
Cause of death given as "Septic infection" "Comp. fracture left forearm."

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Auto wreck over grade near Kamiah Idaho.

E G Braddock

MAR 17 1972

RECEIVED OCT 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68054

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

118B

2. FULL NAME Margaret Gilligan
(a) Residence. No. St Joseph Hospital St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1896

7. AGE Years 33 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Nun.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Sisters of St. Joseph.

9. BIRTHPLACE (city or town) (State or country) Pittsburg Penn.

PARENTS
10. NAME OF FATHER John Gilligan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.
12. MAIDEN NAME OF MOTHER Margaret
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland.

14. Informant Sisters of St. Joseph
(Address) Lewiston Idaho

15. Filed Sept 12, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30th, 1929, to Sept 1st, 1929
that I last saw her alive on Sept 1st, 1929
and that death occurred, on the date stated above, at 1:55 P. m.
The CAUSE OF DEATH* was as follows:

Obstruction Intestinal chronic (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) general adhesions
Small Intestines (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Aug 1928 Dic 1928 Aug 8th 1929
Was there an autopsy? No
What test confirmed diagnosis? fecal vomiting & obstruction
(Signed) O. C. Carsson, M. D.
Sept 2nd, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho Date of Burial Sept 3, 1929

20. Undertaker Vassar Mortuary Inc. Address Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68055

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph) 96B
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Ruth Bucklett

(a) Residence. No. Sweetwater Idaho St. Sweetwater Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Indian
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joe Rickman

6. DATE OF BIRTH (month, day and year)

7. AGE — Years 34 — Months — Days — If LESS than 1 day ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kamiah Idaho

PARENTS
10. NAME OF FATHER Sam Bucklett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Henry George
(Address) Kamiah Idaho

15. Filed Sept 10 1929 Simon E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1929, to Aug 29 1929, that I last saw h alive on Aug 29 1929 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:
Brain abscess

(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Mastoiditis
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of June 24 29
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W O Clark, M. D.
Aug 30 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kamiah Idaho	8/31 1929
20. Undertaker	Address
Vassar Mortuary	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 28 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68056

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce

City of Spalding

Registration District No. 128

Primary Registration District No.

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrtle Mae Maupin

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: August 7 1929 (Month) (Day) (Year)

7. AGE: Yrs. 1 Mos. 23 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: (Child)
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spalding, Idaho.

10. NAME OF Father: Robert Boyd Maupin.

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Calla Kingsley

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Robert Boyd Maupin Lapwai, Idaho

15. Filed Sept. 1 1929 George Gaigmard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 204 25 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,
that I last saw h... alive on ....., 19...,
and that death occurred on the date stated above, at 10:30 A.M.
The CAUSE OF DEATH* was as follows:
Died suddenly. Probably influenza
(Duration) yrs. mos. ds.
No physician called.
Contributory (Secondary)
(Duration) yrs. mos. ds.

9/25 1929 (Signed) Leo O Keefe M. D.
(Address) Lapwai Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spalding Ida. DATE OF BURIAL: 9/26 1929

20. UNDERTAKER: Brown Bros Lewiston Ida. ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 26 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68057

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce Registration District No. 128

City of Lapwai Idaho Primary Registration District No.

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Indian 4/4	Single

6. DATE OF BIRTH: Sept (Month) 6 (Day) 1929 (Year)

7. AGE: ....Yrs....Mos....ds. 2 — IF LESS than 1 day how many 11 hrs. or 50 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF Father Joseph White

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Isabel George

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Joseph White
(Address) Lapwai Idaho.

15. Filed Sept 1929 George Gaynard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 20-B 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6- 1929, to Sept 7- 1929
that I last saw him alive on Sept 7- 1929
and that death occurred on the date stated above, at 1:30 P.M.
The CAUSE OF DEATH* was as follows:
Not known

(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) George Gaynard M. D.
9/8/1929 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lapwai Idaho — DATE OF BURIAL Sept 9- 1929

20. UNDERTAKER Brewer-Wann — ADDRESS Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 11-1 RECEIVED OCT 26 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68058
Local Registrar's No.

1. PLACE OF DEATH
County of Nez Perce
City of Lapwai
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128
Primary Registration District No.
(No. St.)

2. FULL NAME Eddie Grimes Jr. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Indian 4/4
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: June (Month) 4 (Day) 1916 (Year)

7. AGE: 13 Yrs. 1 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): California

10. NAME OF Father: Eddie Grimes

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo O Keck
(Address) Lapwai Idaho.

15. Filed July 1929 George Gaugnard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1929, to July 31 1929, that I last saw him alive on July 30 1929, and that death occurred on the date stated above, at 12 a M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) ..... yrs. 6 mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo O Keck M. D.
7/31 1929 (Address) Lapwai, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 1 mos. 28 days. In the State ..... yrs. 1 mos. 28 ds.
Where was disease contracted if not at place of death? Oregon
Former or usual residence Smith River California

19. PLACE OF BURIAL OR REMOVAL: Fort Lapwai Sanatorium
DATE OF BURIAL: 7/31 1929

20. UNDERTAKER: Brower & Warm
ADDRESS: Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED OCT 26 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68059

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce

City of near Arrow, Idaho.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ohnawyahtonsumtmy Ohnawyahtonsumtmy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 74 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF Father: Is too kas

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Hug Toir

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Armstrong

(Address) Arrow Idaho.

15. Filed Aug 1929 George Gaymard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-6- 1929, to 8-8- 1929 that I last saw h[illegible] alive on 8-8- 1929, and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. , mos. 8 ds.

(Signed) George Gaymard M. D.

8/8/1929 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL 1929

20. UNDERTAKER — ADDRESS —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 26 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of Webb Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

State File No. 68060

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jane Wett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Married~~ Widowed (Write the word)

6. DATE OF BIRTH: Not Known (Month) (Day) (Year)

7. AGE: 90 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF Father: Dave Wolf

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mabel Sky

(Address) Lapwai Idaho R.F.D.

15. Filed July 1929 George Gaignard M.D. (Local Registrar)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 204 (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19...., to ..... 19...., that I last saw h..... alive on ..... 19...., and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Sudden death, Cause unknown

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaignard M. D.

7/25/1929 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Webb Idaho.

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Brower-Wann

ADDRESS: Lewiston Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 26 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of Lapwai

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. St.)

State File No. 68061

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hattie Eugenia George 128

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: Feby (Month) 27 (Day) 1919 (Year)

7. AGE: 10 Yrs. 6 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work (Child)
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF Father: Milton S. George

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Hattie Ax Fell

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo O Keck
(Address) Lapwai, Idaho

15. Filed Sept 1929 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 26 1929, to Sept 24 1929, that I last saw her alive on Sept 24 1929, and that death occurred on the date stated above, at 2 30 P. M.

The CAUSE OF DEATH* was as follows:
Acute Parenchymatous Nephritis.

(Duration) ..... yrs. 2 mos. ..... ds.

Contributory (Secondary) Acute Myocarditis

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) Geo O Keck M. D.

9/24 1929 (Address) Lapwai, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 1 mos. 29 days. In the State 10 yrs. 6 mos. 28 ds.
Where was disease contracted if not at place of death? Stites Idaho.
Former or usual residence Stites Idaho.

19. PLACE OF BURIAL OR REMOVAL: Kamiah Idaho

DATE OF BURIAL: 9/26 1929

20. UNDERTAKER: Brower-Warren Co

ADDRESS: Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 26

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, with unfading ink—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 93

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Lapwai or
City No. East Lapwai Sanatorium St. Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Hattie Eugenia George

(a) Residence. No. Kamiah, Idaho St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	4/4 Nez Perce Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	10	6	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work (School)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kamiah
(State or country) Idaho

PARENTS
10 NAME OF FATHER Milton George
11 BIRTHPLACE OF FATHER (city or town) Kamiah
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Harriet Axtell
13 BIRTHPLACE OF MOTHER (city or town) Kamiah
(State or country) Idaho

14 Informant Geo. O. Keck M.D.
(Address) Lapwai, Idaho

15 Filed Sept. 24, 1929 H. McMaxwell REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1929

17 I HEREBY CERTIFY, That I attended deceased from August 26, 1929, to Sept. 24, 1929, that I last saw her alive on Sept. 24, 1929, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (SECONDARY) Acute Myocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted
If not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo. O. Keck, M. D.
9/24, 1929 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Kamiah Cemetery	Sept. 26 1929
20 UNDERTAKER	**ADDRESS**
Brower-Wann Co	Lewiston

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 7 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26

Primary Registration District No. 2069

File No. 62964

Registered No. 29

1. PLACE OF DEATH

County of Oneida

City of Malad

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George L. Krantzeg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH

Jan (Month) 15 (Day) 1904 (Year)

7. AGE

25 Yrs. 8 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Day Labor

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Malad Ida.

10. NAME OF FATHER Frank P. Krantzeg

11. BIRTHPLACE OF FATHER (State or Country) Manti Utah.

12. MAIDEN NAME OF MOTHER Sarah A. Marston

13. BIRTHPLACE OF MOTHER (State or Country) Weston Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H.S. Krantzeg

(Address) Malad Ida

15. Filed 10-31 1929

J.M. Kerns
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1929 to Oct 3 1929 that I last saw him alive on Oct 3 1929, and that death occurred on the date stated above, at 4 05 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis mitral regurgitation.

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) H.H. Marley M. D.

10-4 1929 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Ida	Oct. 6 1929
20. UNDERTAKER	**ADDRESS**
J. Guy Herman	Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 7 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida

City of Stone

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26

Primary Registration District No. 2069

(No. ..... , ... St.)

File No. 68065

Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles William Robbins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Single

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: White (Write the word.)

6. DATE OF BIRTH: Oct- (Month) 1 (Day) 1907 (Year)

7. AGE: 22 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming -

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Stone Idaho

10. NAME OF FATHER: Hulbert B. Robbins

11. BIRTHPLACE OF FATHER (State or Country): Curlew Utah -

12. MAIDEN NAME OF MOTHER: Mary Ellen Jackson

13. BIRTHPLACE OF MOTHER (State or Country): Derby England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H B Robbins

(Address) Stone Ida

15. Filed 10-31 1929 J. M. Kerns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct- (Month) 1- (Day) 1929 (Year) 90

17. I HEREBY CERTIFY, That I attended deceased from Sept 21, 1929, to Oct 1st 1929 that I last saw him alive on Oct 1 1929 and that death occurred on the date stated above, at 10 a M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart

Rheumatic

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Follicular Tonsilitis

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) O. E. Wardleigh M. D.

10-1 1929 (Address) Snowville Utah

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Snowville Ut.

DATE OF BURIAL: Oct 3 1929

20. UNDERTAKER: J. Guy Benson

ADDRESS: Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 26

DO NOT WRITE IN THIS SPACE
State File No. 68066

PLACE OF DEATH.
County of Oneida
City of Malad

Registration District No. ~~26~~
Primary Registration District No. 2069
Local Registrar's No. 27

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James McKay

(a) Residence. No. ..... Malad St. 483

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 11, 1866

7. AGE — Years: 62 | Months: 9 | Days: 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Salt Lake City

PARENTS

10. NAME OF FATHER: Jos B McKay
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Jane Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: Mrs Jas McKay
(Address): Malad Ida.

15. Filed 10-31, 1929 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 25 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1929 to Sept. 25, 1929
that I last saw h~~e~~r alive on Sept. 26, 1929
and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of ~
Was there an autopsy? no What test confirmed diagnosis? Physical findings

(Signed) V. P. Grant, M. D.
Sept. 29, 1929 (Address) Malad, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Malad Ida. Date of Burial: Sept. 29 1929

20. Undertaker: D. E. Johnson. Address: Burley, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 1-15 M. 1-19 RECEIVED NOV 7 1929

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Oneida

City of Holbrook

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26

Primary Registration District No. 2069

(No. ..... St.)

File No. 68067

Registered No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Gurney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH: Sept (Month) 18 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Holbrook Ida

10. NAME OF FATHER: Edgar Eugene Gurney

11. BIRTHPLACE OF FATHER (State or Country): Red Cloud Nebraska

12. MAIDEN NAME OF MOTHER: Ethel Goss

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E E Gurney

(Address) Holbrook

15. Filed 10-31 1929 J. M. Kerns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 24 (Day) 1929 (Year) 159e

17. I HEREBY CERTIFY, That I attended deceased from Sept 18, 1929, to Sept 24 1929 that I last saw him alive on Sept 24 1929, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Pulmonary Stenosis

Blue Baby

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A E Vandeighma M. D.

9/24 1929 (Address) Snowville Utah

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Snowville Utah

DATE OF BURIAL: Sept 25 1929

20. UNDERTAKER: Jos J Larkin

ADDRESS: Snowville Tex

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68068

PLACE OF DEATH
County of Owyhee
City of Homedale — Registration District No. 3 — Primary Registration District No. 2005
Local Registrar's No. 114
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edith B. Mullen

(a) Residence. No. Homedale Idaho St. 101A
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 23-1861

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS
10. NAME OF FATHER Thaddeus Bullard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't know
12. MAIDEN NAME OF MOTHER Estella Newman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't know

14. Informant Mrs O. H. Johns
(Address) Homedale Idaho

15. Filed 10-26-, 1929 John D. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19, 1929, to Oct 24, 1929, that I last saw h[illegible] alive on Oct 22, 1929, and that death occurred, on the date stated above, at 4-35 a.m.

The CAUSE OF DEATH* was as follows: Double Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis? None
(Signed) Roland E Talbot, M. D.
Oct 26, 1929 (Address) Wilder Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	10-25 1929
20. Undertaker C. V. Packham	Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68069

Local Registrar's No. 28

PLACE OF DEATH

County of Power

City of ~~American Falls~~, Rockland

Registration District No. 29

Primary Registration District No. 2072

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sariah Hartley

(a) Residence. No. Rockland, Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Richard Hartley

6. DATE OF BIRTH (month, day and year) Jan 1st 1856

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	73	9	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER William Cooper

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Chas H. Hartley

(Address) American Falls, Idaho

15. Filed Oct. 26, 1929 Emerson Nolt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-24, 1929, to 10-24, 1929

that I last saw he alive on 10-24, 1929

and that death occurred, on the date stated above, at 10-40a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholecystitis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W F Logan, M. D.

, 19 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rockland	Oct 26 1929

20. Undertaker Geo Davis Address American Falls, Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68070

PLACE OF DEATH
County of Power
City of American Falls Idaho

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 27

2. FULL NAME Jacob Gehring Jr. American Falls Idaho
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6. DATE OF BIRTH (month, day and year) Oct 21 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) American Falls Idaho

PARENTS
10. NAME OF FATHER Jacob Gehring
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Christina Ruff
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant Christina Gehring
(Address) American Falls Idaho

15. Filed Oct. 23, 1929 Gwenn Noth Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21, 1929, to Oct 21, 1929
that I last saw him alive on Oct 21, 1929
and that death occurred, on the date stated above, at 5 P.M. m.
The CAUSE OF DEATH* was as follows: 31 -
Premature birth - Week of gestation. Cause. Tuberculosis. Pulmonary of mother.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Tuberculous Coughing of mother
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) M. C. MacKinnon, M. D.
10-23, 1929 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pleasant Valley Cemetery American Falls Ida
Date of Burial Oct 23 1929

20. Undertaker Friends
Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68071

PLACE OF DEATH

County of Power
City of American Falls
Idaho

Registration District No.
Primary Registration District No.
(No. Bethany Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

162

2. FULL NAME Marvin Leroy Burgemeister

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 12 1928

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Power Co Ida.

PARENTS

10. NAME OF FATHER Martin Burgemeister

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~~Rumania~~ Roumania

12. MAIDEN NAME OF MOTHER Georgia Worley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ore

14. Informant Martin Burgemeister
(Address) American Falls, Idaho

15. Filed Oct 10, 1929 Emerson Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9, 1929, to Oct 9, 1929
that I last saw him alive on Oct 9, 1929
and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:
Meningitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Gastro-Enteritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W H Logan M. D.
Oct 10th, 1929 (Address) Am Falls. Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I.O.F Cemetery	Oct 12 1929

20. Undertaker A W Davis Address American Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68072

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 122

100 B

2. FULL NAME Donald Edward Dunn
(a) Residence. No. Still Spur St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 14 - 1929

7. AGE Years Months Days 15 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS
10. NAME OF FATHER J. E. Dunn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Miss.
12. MAIDEN NAME OF MOTHER Edith Carrick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Mr J. E. Dunn
(Address) Wallace Idaho

15. Filed Nov 1, 1929 J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28, 19, to Oct 29, 1929
that I last saw him alive on Oct 29, 1929
and that death occurred, on the date stated above, at 3p m.
The CAUSE OF DEATH* was as follows:
Capillary Bronchitis
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) James R Bean, M. D.
10/30/29, 19 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace Idaho
Date of Burial Nov 30 1929 Shipped

20. Undertaker J. A. Bever Ward and Co.
Address Wallace Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 16 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68073

Local Registrar's No. 121

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. ..... St.)

2. FULL NAME Mrs. W. W. Ruggles

1013

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Aug. (Month) 21 (Day) 1907 (Year)

7. AGE: Yrs. 22 Mos. 2 ds. 4
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Col. Spring, Miss.

10. NAME OF Father: John H. Schmitz

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Anna Tether

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. W. Ruggles
(Address) Burke Ida.

15.
Filed Oct 27 1929 J. L. Quigley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/22/29 19..., to 10/24/29 19..., that I last saw her alive on 10/22/29 19..., and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) (Confinement 10/17/29)

(Duration) ..... yrs. ..... mos. ..... ds.

10/25/1929 (Signed) James R Bean M. D.
(Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mesplerce Ida. DATE OF BURIAL: Oct 27 1929

20. UNDERTAKER: Bruce G. Harstell ADDRESS: Wallace

RECEIVED NOV 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68074

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 120

2. FULL NAME Josephine Reynolds 74a
(a) Residence. No. Mullan, Idaho St. Mullan, Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 19 - 1858

7. AGE Years 71 Months 5 Days 3 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dover Kentucky.

PARENTS
10. NAME OF FATHER Wm M. Reynolds.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Sarah J. Jennings.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky.

14. Informant Mrs C Wheatley
(Address) Mullan Idaho.

15. Filed Oct 24, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24, 1929, to Oct 22, 1929
that I last saw her alive on Oct 21, 1929
and that death occurred, on the date stated above, at 12:50 P.m.
The CAUSE OF DEATH was as follows:
Cerebral Hemorrhage
Glosso-labio laryngeal paralysis
Recurrence. 3 time
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? a home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F W Ralf, M. D.
Oct 23, 1929 (Address) F W Mullan Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mullan, Idaho. Date of Burial Oct 24 1929.
20. Undertaker J. A. Bever Ward Und Co. Address Wallace Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68075

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 119

2. FULL NAME Sarah M. Stewart

(a) Residence. No. 410 River St. St. 129
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Divorced

6. DATE OF BIRTH (month, day and year) Nov. 4 - 1859

7. AGE Years 69 Months 11 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer - Invalid.

9. BIRTHPLACE (city or town) (State or country) California

PARENTS
10. NAME OF FATHER John St Clair
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant J. E. Rose
(Address)

15. Filed Oct 20, 1929. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Oct 19, 1929
that I last saw her alive on Oct 19, 1929
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis? Physical Examination
(Signed) R. E. Wereich, M. D.
Oct 19, 1929 (Address) Wallace Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace Idaho — Date of Burial Oct 20 1929

20. Undertaker J. A. Bower Ward and Co. — Address Wallace Idaho

RECEIVED NOV 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68076

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 128

100a

2. FULL NAME Bernice Veda Carli

(a) Residence. No. Yellow Dog St. Yellow Dog.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joe Carli.

6. DATE OF BIRTH (month, day and year)

7. AGE Years 19 Months 2 Days 28. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spokane Wash.

PARENTS
10. NAME OF FATHER John Lynch.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Clara Kirchoff.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Neb.

14. Informant Joe Carli
(Address) Yellow Dog Idaho.

15. Filed Oct 16, 1929. J. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24th, 1929, to Oct 14, 1929
that I last saw her alive on Oct 14, 1929
and that death occurred, on the date stated above, at 4:30 P.m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema Rt Thorax
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Drainage of Pleura. Oct 7 1929
Was there an autopsy? no
What test confirmed diagnosis? Phys Signs
(Signed) Max F. Smith M. D.
11/14/29, 19 (Address) Wallace Ida

*State the DISEASE CAUSING DE[redacted] in deaths from VIOLENT CAUSES, state (1) MEANS AND [redacted]E OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, [redacted]MICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial Oct 16 1929

20. Undertaker J. A. Bevers Ward Und. Co. Address Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV. 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68077

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 117

2. FULL NAME Gertrude Wearne

(a) Residence. No. ..... St. 49
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or ~~Divorced~~ (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of George Wearne

6. DATE OF BIRTH (month, day and year) June 19 - 1871

7. AGE Years 58 Months 2 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER Wm Thomas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Emma
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Cora Drake
(Address) Gem, Idaho

15. Filed Oct 15, 19.. F. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1928, to Oct 12, 1929
that I last saw her alive on Oct 12, 19..
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows: General Carcinomatosis - No primary area found - First an axillary gland then other tumors appeared. (duration) Several mos. ..... ds.
CONTRIBUTORY (Secondary) None
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of May 1928
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Drs McWerry M. D.
10/13, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace Idaho. Date of Burial Oct 15 1929

20. Undertaker J. A. Owen Ward Und. Co. Address Wallace, Ida.

RECEIVED APR 7 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68077

Dr. H.C. Mowery
Wallace

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Gertrude Wearne who died at Wallace, Idaho on Oct. 12, 1929
Cause of death given as "General Carcinomatosis."

Information DESIRED in order to complete certificate:

PLEASE STATE THE PRIMARY SEAT OF THE DISEASE WHENEVER CANCER, CARCINOMA, SARCOMA, ETC. ARE RETURNED WITHOUT QUALIFICATIONS.

PLEASE ANSWER BELOW:

Fresh an axillary gland soon other tumors appeared no primary area found

H C Mowery

FORM V. S. No. 5-25 M. 1-19

RECEIVED NOV 16 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

State File No. 68078

Local Registrar's No. 116

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Geo Edmonds

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: April (Month) 5 (Day) 1881 (Year)

7. AGE: ..... Yrs. 38 Mos. 6 ds. 7

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Blackman England

10. NAME OF Father: James Edwards

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Edmonds

(Address) Burke Ida

15.

Filed Oct 15 1929 F. L. Quigley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 12 (Day) 1929 (Year) 14.6

17. I HEREBY CERTIFY, That I attended deceased from 9/28 1929 to Oct 12th 1929, that I last saw her alive on Oct. 12th 1929, and that death occurred on the date stated above, at 9.30 P M.

The CAUSE OF DEATH* was as follows:

Septicemia Puerperal

..... (Duration) ..... yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Mowery M. D.

10/14 1929 (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida

DATE OF BURIAL: 10-15 1929

20. UNDERTAKER: Bruce G. Worstell

ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 16 [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68079

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 115

119

2. FULL NAME Edith Stevens

(a) Residence. No. Canyon Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 5 1924

7. AGE	Years	Months	Days	If LESS than 1 day,
	4	3	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS
10. NAME OF FATHER John Stevens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland
12. MAIDEN NAME OF MOTHER Anna Nylund
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant John Stevens
(Address) Wallace Idaho.

15. Filed Oct 13, 1929 F. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30, 1929, to Oct 10, 1929, that I last saw her alive on Oct 10, 1929, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:
Intestinal Indigestion
14
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

10/17/29 (Signed) James R. Dean, M. D.
(Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho.	Oct 13 1929
20. Undertaker J. A Bower Ward Und. Co.	Address Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68080

PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

(No. Providence, Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 114

48B

2. FULL NAME Frank Garmark

(a) Residence. No. Burke, Idaho St. Burke, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year)

7. AGE 59 Years | Months | Days | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10. NAME OF FATHER John Garmark

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Belgium

12. MAIDEN NAME OF MOTHER Hearsh

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Roy Wolfe
(Address) Burke Idaho

15. Filed Oct 12, 1929. F. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 9 1929
(Month) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ___, 1927, to Oct 9, 1927

that I last saw h___ alive on ___

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH was as follows:

Myocarditis chron
Ex. B. Pulmon
Arty. Both Lungs
Second

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) F.B.

(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1927

Was there an autopsy? No none

What test confirmed diagnosis?

(Signed) Dris Mowery M.D.

10/10, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace Idaho. Date of Burial: Oct 12 1929

20. Undertaker J. A. Bwer Ward, Und. Co. Address: Wallace, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PA

DO NOT WRITE IN THIS SPACE

State File No. 68081

PLACE OF DEATH

County of Shoshone

City of Anderson Siding

Registration District No. 70

Primary Registration District No. 1011

(No. Residence)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 113

162

2. FULL NAME Glenn Chapen

(a) Residence. No. Residence, add. Brichard St. Anderson Siding
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred: yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 24 - 1929

7. AGE Years Months 1 Days 10 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS

10. NAME OF FATHER J. D. Chapen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ore.

12. MAIDEN NAME OF MOTHER Lucile Eamon

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) B. C.

14. Informant J. D. Chapen
(Address) Anderson Siding

15. Filed Oct 5, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 5:40 A m.

The CAUSE OF DEATH* was as follows: Morasmus

(duration) yrs. several mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. several mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) R. S. Mowery M. D.

10/4/29 19 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace Idaho

Date of Burial Oct 5 1929

20. Undertaker J. A. Brown Ward Mtn Co.

Address Wallace, Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 16 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

State File No. 68082

Local Registrar's No. 112

122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Karl T. Sparks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: May (Month) 25 (Day) 1892 (Year)

7. AGE: ..... Yrs. 37 Mos. 4 ds. 5

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mining Engineer

(b) General nature of industry, business or establishment in which employed (or employer): Mine Owners Assn

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF Father: Wm. T. Sparks

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Emma Rogaske

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister Superior

(Address) Providence Hospital

15. Filed Oct 4 1929 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1929 to Oct 2 1929 that I last saw him alive on Oct 2 1929 and that death occurred on the date stated above, at 12:49 A.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis Liver

Atrophic

(Duration) Several yrs. ..... mos. ..... ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Drs Mowery M. D.

10/2 1929 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: 10-4 1929

20. UNDERTAKER: Bruce G. Worstell ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68083

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 46
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Ernest Crane 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 10, 1858

7. AGE

Years	Months	Days	If LESS than 1 day,
71	2	3	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Oregon

PARENTS

10. NAME OF FATHER: Silas W. Crane
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Elizabeth Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: W J Crane
(Address): Kellogg, Idaho

15. Filed Oct. 14, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH Lindsay

16. DATE OF DEATH: Oct (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15th, 1929, to Oct 13, 1929, that I last saw him alive on Oct 13, 1929, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:
Valvular heart disease.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Symptomatology
(Signed) W C Lindsay, M. D.
10/14, 1929 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Harrison Idaho
Date of Burial: Oct 14 1929

20. Undertaker: M. C. Thornhill
Address: Kellogg, Ida.

RECEIVED NOV 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68084

PLACE OF DEATH
County of Shoshone
City of Avery

Registration District No. 127
Primary Registration District No. 2400
(No.) 1616
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

2. FULL NAME Sophie Margaret Schmalhorst

(a) Residence. No. 31 hours St.
(Usual place of abode)
Length of residence in city or town where death occurred. ~~yrs.~~ ~~mos.~~ ~~ds.~~ How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 29-1929

7. AGE Years	Months	Days	If LESS than 1 day,
~~Years~~	~~Months~~	31 hours	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) Avery-Idaho

PARENTS

10. NAME OF FATHER Hubert F. Schmalhorst
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Sophie H. Rangsten
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) South Carolina

14. Informant Sophie H. Schmalhorst
(Address) Avery-Idaho

15. Filed Oct. 30, 1929 C O Bussey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29-30, 1929, to , 19
that I last saw h~~e~~r alive on Oct. 30, 1929
and that death occurred, on the date stated above, at 3p m.
The CAUSE OF DEATH* was as follows:
Premature at birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C O Bussey, M. D.
Oct. 30, 1929 (Address) Avery-Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mica Station, Idaho	Oct 31 1929
20. Undertaker None	Address —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 28 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 68085
Registered No. 111

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Buckley Tony 74a

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): unknown
6. DATE OF BIRTH. unknown (Month) (Day) 1 (Year)
7. AGE ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Labor
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) unknown
10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (State or Country)
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (State or Country) —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. M. Rogers
(Address) Wallace Ida.
15. Filed Oct 3 1929 J. P. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 30 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 1st 1926 to 9-30- 1929, that I last saw him alive on 9-30- 1929, and that death occured on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
10/1 1929 (Signed) James R Benn M. D.
(Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. 3 yrs. 7 mos. 29 days. In the State..... yrs..... mos..... days
Where was disease contracted if not at place of death? Osborne
Former or usual residence Wardner

19. PLACE OF BURIAL OR REMOVAL: Kellogg Ida. DATE OF BURIAL: 10-3 1929
20. UNDERTAKER: P. F. Stant ADDRESS: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

RECEIVED OCT 28 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68086

PLACE OF DEATH

County of Shoshone

City of Black Cloud

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 110

(No. 90) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Angus Douglas Marshall

(a) Residence. No. Wallace, Idaho St. Black Cloud.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) March 31 - 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	5	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Prospector.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nova Scotia.

PARENTS

10. NAME OF FATHER Douglas Marshall

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Helen Henry.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland.

14. Informant John Marshall

(Address) Wallace Idaho.

15. Filed Dec 1, 1929. J. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH was as follows:

Hoped deposit would pick up already Heart fail

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Cirrhosis Liver

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) H. Morley Coroner

9/30, 19 29 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho.	Dec 1, 1929
20. Undertaker J. G. Bever	Address
Ward Und. Co.	Wallace, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 28 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68087

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 109

41

2. FULL NAME Anna Bell Pollard
(a) Residence. No. Burke, Idaho St. Burke, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Andrew J. Pollard

6. DATE OF BIRTH (month, day and year) Feb 26 - 1892

7. AGE Years 37 Months 8 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mountain Home Ark.

PARENTS

10. NAME OF FATHER J. H. McIntyre
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Leana Pittman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Andrew John Pollard
(Address) Burke Idaho

15. Filed Sept 26, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/17/29, 19..., to 9/24, 1929
that I last saw her alive on 9/24/29, 19...
and that death occurred, on the date stated above, at 2:05 P.m.
The CAUSE OF DEATH* was as follows:
Septicemia following Extraction of tooth
(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) James R Bean, M. D.
9/25/29, 19... (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace Idaho. Date of Burial Sept 26 1929

20. Undertaker J. A. Beaver Ward Und. Co. Address Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 28 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68088

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 10, 11
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 108

49

2. FULL NAME Chas Melroy
(a) Residence. No. Mullan, Idaho St. Midnight Mine
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ May Melroy
6. DATE OF BIRTH (month, day and year) Feb 13 - 1860
7. AGE 69 Years Months 7 Days 10 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Midnight Mng. Co.
9. BIRTHPLACE (city or town) (State or country) Iowa
PARENTS
10. NAME OF FATHER James Melroy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Margaret Gallagher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland
14. Informant Mrs Chas Melroy
(Address) Wallace, Idaho
15. Filed Sept 27, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 23 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 22, 1929, to Sept 23, 1929
that I last saw h..... alive on ....., 1929
and that death occurred, on the date stated above, at 4:30 A. m.
The CAUSE OF DEATH* was as follows: Angina Pectoris
..... (duration) ..... yrs. ..... mos. 1/2 ds.
CONTRIBUTORY (Secondary) Coronary Sclerosis
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Don Mowery, M. D.
9/23, 1929 (Address) Wallace Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Murray Idaho Date of Burial Sept 27 1929
20. Undertaker J. A. Bever Ward Und Co. Address Wallace, Idaho

FORM V. S. No. 5-25 M. 1-19

RECEIVED OCT 28 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

State File No. 68089

Local Registrar's No. 107

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Ann Etta Peel 44a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~M~~ F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: May (Month) 11 (Day) 1 (Year)

7. AGE: 61 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ontario Canada

10. NAME OF Father: Wallet Potter

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Ruth Brown

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. S. Ellis

(Address) Wallace

15. Filed Sept 22 1929 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 31 1929, to Sept. 21 1929, that I last saw her alive on Sept. 20 1929, and that death occurred on the date stated above, at 2:50 AM.

The CAUSE OF DEATH* was as follows:

Ac Endocarditis

(Duration) ..... yrs. 2 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Max T. Smith M. D.

9/21/29 19 (Address) Wallace, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence Wallace, Idaho

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene Ida

DATE OF BURIAL: 10-23 1929

20. UNDERTAKER: Bruce G. Horstell

ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. RECEIVED OCT 28 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

State File No. 68090

Local Registrar's No. 106

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME E. J. Nelson 100a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: Dec (Month) 2 (Day) 873 (Year)

7. AGE: 55 Yrs. ..... Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF Father: Nels Erickson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Annie Oleson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Nelson
(Address) Deceased

15. Filed Sept 20 1929 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10th 1929, to Sept 19th 1929 that I last saw him alive on Sept 18th 1909 and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Cholelithiasis

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) Cholecystectomy

(Duration) ..... yrs. ..... mos. 9 ds.

(Signed) Max T. Smith M. D.

9/19/29 19 (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida. DATE OF BURIAL: 9-22 1929

20. UNDERTAKER: Bruce G. Warstell ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 14 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68090

Dr. M.T. Smith
Wallace

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

E.J. Nelson who died at Wallace, Idaho on Sept. 19, 1929
Cause of death given as "Broncho Pneumonia." "Cholecystectomy."

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Cholecystectomy

M. T. Smith

6-11-30

FORM V. S. No. 5-25 M. 1-19

RECEIVED OCT 28 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

State File No. 68091

Local Registrar's No. 105

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hans Christeanson 48B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Jan (Month) 6 (Day) 1 (Year)

7. AGE: 64 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sexton
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF Father: Melville Christeanson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Margret Olestead

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Sullivan
(Address) Portland Oregon

15. Filed Sept 20 1929 F. L. Quidey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1929, to Sept 18 1929 that I last saw him alive on Sept 18 1929 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis Chr

(Duration) Several yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) Several yrs. ..... mos. ..... ds.

(Signed) Dr. Mowry M. D.

(Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida

DATE OF BURIAL: 9-20 1929

20. UNDERTAKER: Bruce S. Worstell

ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 28 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68092

PLACE OF DEATH
County of Shoshone
City of Mace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 104

2. FULL NAME Mary Kitkoski 90.
(a) Residence. No. 1 Mace, Idaho St. Mace Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) Sept 8 - 1857

7. AGE Years 72 Months 0 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Poland

PARENTS
10. NAME OF FATHER Creslak
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Poland
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Poland

14. Informant John Kitkoski
(Address) Wallace, Idaho.

15. Filed Sept 19, 1929. T. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....
that I last saw her alive on Sept 16, 1929
and that death occurred, on the date stated above, at 4:30 P m.
The CAUSE OF DEATH* was as follows:
Heart failure
(duration) yrs. mos. ds.
Instant
CONTRIBUTORY (Secondary) myocarditis Gen Fatty Dege
generation (duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. Mowery M. D.
9/17, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial Sept 19 1929

20. Undertaker J. A. Bever Ward Undertaking C. Address Wallace, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V.S. No. 5-25 M-1-19

RECEIVED OCT 28 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68093

Local Registrar's No. 103

1. PLACE OF DEATH

County of Shoshone Registration District No. 10

City of Wallace Primary Registration District No. 1011

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claude Whittecar 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: April (Month) 4 (Day) 1911 (Year)

7. AGE: 18 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Grays Harbor

10. NAME OF Father: Herbert Whittecar

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Blanche Pierce

13. BIRTHPLACE OF MOTHER (State or Country): Vanwyard Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herbert Whittecar
(Address) Clarkston Wash.

15. Filed Sept 17 1929 J. R. Langley Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1929, to Sept 15 1929, that I last saw h[illegible] alive on Sept 15 1929, and that death occurred on the date stated above, at 2 25 P.M.

The CAUSE OF DEATH* was as follows:

Pyonephrosis

(Duration) ..... yrs. 1 mos. ..... ds.

Contributory (Secondary) Spinal Chord fibrosis following Cerebro-spinal Meningitis

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) T. C. Werley M. D.

19 ..... (Address) Wallace Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: 9-17 1929

20. UNDERTAKER: Grace G. Nordt — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 28 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68094

PLACE OF DEATH
County of Shoshone
City of Mullan

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 102

(No. Residence 204) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Milo Silas Mossburg

(a) Residence. No. Mullan, Ida. St. Mullan, Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Dec 4 - 1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	19	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Federal Mng. Co.

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER Phillip Mossburg.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dubuque Iowa.
12. MAIDEN NAME OF MOTHER Mary Collins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa.

14. Informant Mrs Beatrice Dean
(Address) Mullan Ida.

15. Filed Sept 17, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____
that I last saw him alive on ____, 19____
and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:

Coma caused by
Loss of blood
Hemorrhage of
Lungs (duration) yrs. 2 mos. 1 ds.
CONTRIBUTORY (Secondary) Pulmonary
Tuberculosis (duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Mary Collins Mossburg M.
Sept 9, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	Sept 12 1929
20. Undertaker J. A. Beer Ward Undertaking Co.	Address Wallace, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 28 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68095

PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 101

(No. 463)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emily Mabel Moley

(a) Residence. No. ..... St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 25 1891

7. AGE	Years	Months	Days	If LESS than 1 day,
	38	10	18	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Robt G. Schofield

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Emily Bale

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Syretha M. Costello

(Address) Bellingham, Wash.

15. Filed Sept 10, 1929 J. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 7 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 '29, to Sept 7 '29

that I last saw her alive on Sept 7 '29

and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chr Parenchymatous nephritis

Multiple Uterine fibroids (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hysterectomy 9-7-29

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 7 '29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Max T. Smith, M. D.

9/9/29, 19 (Address) Max T. Smith

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane, Wash	Sept 10 1929
20. Undertaker	Address
M. C. Thornhill	Kellogg Ida

RECEIVED JUN 14 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68095

Dr. M.T. Smith
Wallace, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Emily Mabel Nisley who died Sept. 7, 1929 at Wallace, Idaho
Cause of death given as "Myocarditis. Chronic parenchymatous nephritis."
"Hysterectomy 9-7-29."

Information DESIRED in order to complete certificate:

PLEASE GIVEN THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WASPERFORMED.

PLEASE ANSWER BELOW:

Please

Multiple Uterine Fibroids

M T Smith

6-11-30

FORM V. S. No. 5-25 M. 1-19

1. PLACE OF DEATH

RECEIVED OCT 28 1929

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

2. FULL NAME Walter Lyle Slocum

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68096

Local Registrar's No. 100

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Dec. (Month) 10 (Day) 1900 (Year)

7. AGE: 28 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer): Hunter Helfer Morning Mining Co

9. BIRTHPLACE (State or Country): Stevens County Wn.

10. NAME OF Father: Ralph A. Slocum

11. BIRTHPLACE OF FATHER (State or Country): Lincoln Co. Me.

12. MAIDEN NAME OF MOTHER: Elizabeth Beaver

13. BIRTHPLACE OF MOTHER (State or Country): Grafton Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph A. Slocum Jr.

(Address) Wallace Ida.

15.

Filed Sept 6 1929 J. R. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1929, to Sept 4 1929, that I last saw him alive on Sept 3 1929, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. ..... mos. ½ hrs.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Rolfe M. D.

Sept 4 1929 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Valley Mach

DATE OF BURIAL: 9/6/29 19

20. UNDERTAKER: Bruce S. Markell

ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 28 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68097

PLACE OF DEATH
County of Shoshone
City of Mullan

Registration District No. 70
Primary Registration District No. 1011
(No. Morning Mine)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 99

90

2. FULL NAME Frank H. Savage

(a) Residence. No. ..... St. Mullan Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elma Savage

6. DATE OF BIRTH (month, day and year) May 22nd 1865

7. AGE Years 64 Months 3 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer at Head House
(b) General nature of industry, business, or establishment in which employed (or employer) Morning Mine
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Paxton Indiana

PARENTS
10. NAME OF FATHER H. W. Savage
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or [redacted] (State or Country) Ireland

14. Informant Mrs Elma Savage
(Address) Mullan Idaho

15. Filed Sept 5, 29 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:
Apparently Heart failure Dropped Dead
(duration) Instant yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. C. Mowery Corone
9/4/ 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salem Ore. Date of Burial Shipped Sept 5 1929

20. Undertaker Ward Und Und Co Burr Address Wallace Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 28 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68098

Local Registrar's No. 98

1. PLACE OF DEATH

County of Shoshone

City of Burke

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 211

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lawrence E. Webb 1889

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH: April (Month) 20 (Day) 1905 (Year)

7. AGE: 24 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer): Mining Co.

9. BIRTHPLACE (State or Country): Galena Kansas

10. NAME OF Father: Benjiman Webb

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herbert Feldman

(Address) Burke Ida.

15. Filed Sept 3 1929 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....,

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Crushed to death by falling rock

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. C. Mowery Corr. Wallace Ida

9/3 1929 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 2 mos. ..... days. In the State ..... yrs. 2 mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence Galena Kansas.

19. PLACE OF BURIAL OR REMOVAL: Galena Kansas

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Bruce G. Worstell

ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68099

PLACE OF DEATH

County of Teton

City of Driggs

Registration District No. 77

Primary Registration District No. 2176

Local Registrar's No. 11

(No. 20)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Phyllis Rae Christensen

(a) Residence. No. ____ St. ____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 23 - 1912

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	17	7	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Ririe Idaho

PARENTS

10. NAME OF FATHER Orson W. Christensen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Loretta Hochstrasser

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Miss Alice Christensen
(Address) Driggs, Idaho

15. Filed Oct 10 - 1929 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9, 1929, to Oct 9, 1929
that I last saw her alive on —, 19
and that death occurred, on the date stated above, at 3 50 P m.

The CAUSE OF DEATH* was as follows:
asphyxiation
Fainted & fell on head covering face & head —
(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) R. G. Parkinson M. D.
Oct 10, 1929 (Address) Driggs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Driggs, Idaho	10 - 12 - 1929
20. Undertaker	Address
—	—

RECEIVED APR 4 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68099

Dr. G.G. Parkinson
Driggs

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Phyllis Rae Christensen who died at Driggs, Idaho on Oct. 9, 1929
Cause of death given as "Asphyxation"

Information DESIRED in order to complete certificate:

WAS DEATH DUE TO SUICIDE, HOMICIDE, OR ACCIDENT, AND IF THE LAST, WHAT KIND OF ACCIDENT WAS THE PRIMARY CAUSE OF DEATH?

PLEASE ANSWER BELOW:

Accident

Fainted & fell on face causing face & head

G. G. Parkinson

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 4 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Teton

City of Tetonia

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77

Primary Registration District No. 2176

(No. ..... St.)

File No. 68100

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph J. Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March (Month) 17 (Day) 1866 (Year)

7. AGE: 63 Yrs. 6 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Isaac Hill

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Mary Jane Miller

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hyrum D. Hill

(Address) Fish Haven, Ida.

15. Filed 10 — 10 — 1929 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1929 to Oct. 7 1929 that I last saw him alive on Oct. 1 1929 and that death occurred on the date stated above, at 1000 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

Glomerular Nephritis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Cardiac Asthma

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) L. R. Tadeu M. D.

10/8 1929 (Address) Driggs, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Tetonia, Ida.

DATE OF BURIAL: 10/9 1929

20. UNDERTAKER: Wm Hansen; St Anthony Ida by C. Earl Harris Tetonia, Idaho.

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.) Dr. Lamb

2. FULL NAME Marguerite Coolidge Hagerman County Gooding

(a) Residence. No. (Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 16 / 1916

7. AGE	Years	Months	Days	If LESS than 1 day,
	13	5	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) Student
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER J. F. Coolidge
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Olive Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon

14. Informant Mrs. Coolidge
(Address) Hagerman

15. Filed 11-5-, 1929. Dee D. McCowen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 21 (Month) (Day) 4 o'clock 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16th, 1929 to Oct 21, 1929
that I last saw h- alive on Oct 21, 1929
and that death occurred, on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:

Pyogenic infection of the neck of the femur
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) None that could be found (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? Yes Date of Oct 19th 29
Was there an autopsy? No
What test confirmed diagnosis? Clinically
(Signed) H. D. Lamb. M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Oct 23 1929

20. Undertaker I. E. Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PH should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68102

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1088
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Sylvia D Rice
(a) Residence. No. 302 2nd ave N St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Oct 3 / 1857
7. AGE Years 72 Months — Days 16 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Utah
PARENTS
10. NAME OF FATHER Ransom A Becher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Conn
12. MAIDEN NAME OF MOTHER Sylvia Wheeler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio
14. Informant Jennie Morgan
(Address) Twin Falls
15. Filed 11-5-th, 1929 Dr. D. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 19 1929 Dr Lamb
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1929, to Oct 18th, 1929
that I last saw her ~~alive~~ dead on Oct 18th, 1929
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH was as follows:
Apoplexy
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Eye
(Signed) H. E. Lamb, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial Oct 21 1929
20. Undertaker F E Drake
Address Twin Falls

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68103

County of Twin Falls

City of Twin Falls Idaho

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charlotta K. Wanman

(a) Residence. No. Twin Falls Ida, Route #3 St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

100a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July 19th 1859

7. AGE: 70 Years 3 Months 2 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Peter Burstedt

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dont know

14. Informant: A. Wanman,

(Address) Twin Falls, Ida. Route #3

15. Filed 11-5 1929 Dr D. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/16, 1929, to 10/20, 1929

that I last saw her alive on 10/20, 1929 A.M.

and that death occurred, on the date stated above, at 11.15

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. D. Weaver, M. D.

10/22, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls, Idaho

Date of Burial: Oct 23 1929

20. Undertaker: P.J. Grossman

Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68104

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1185

Local Registrar's No.

(No. 720 Main ave No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Helen McKinly

(a) Residence. No. 720 Main ave, No Twin Falls, St. 31
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 30 1901

7. AGE	Years	Months	Days	If LESS than 1 day,
	28	3	18	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Geo. Bausman

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Jennie Bruce

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant John C. McKinley
(Address) 720 Main Ave, No Twin Falls,

15. Filed 10-5, 1929. Dr. D. W. Cowgill
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 18th. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Oct 18, 1929
that I last saw h[illegible] alive on Oct 18, 1929
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory findings

(Signed) W. N. Lutz, M. D.
10-20, 1929 (Address) W N Lutz

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Idaho	Oct, 20 1929
20. Undertaker P. J. Grossman	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated [illegible]TLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68105

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085

Local Registrar's No.

(No.) 74a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Addie Bruce

(a) Residence. No. 1464 8th Ave E St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of W R Bruce

6. DATE OF BIRTH (month, day and year) May 20/1849

7. AGE Years 80 Months 4 Days 22 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10. NAME OF FATHER John Neal
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Mary McClain
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Nora Cornelison
(Address) Twin Falls

15. Filed 10-21, 1929. Dr. D. M. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 2 1929 9-30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1929, to Oct 2, 1929
that I last saw her alive on Oct 2 1929
and that death occurred, on the date stated above, at 9 30 a m.
The CAUSE OF DEATH was as follows:
Cerebral hemorrhage - apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H W Glanchet M. D.
Oct 2, 1929 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial Oct 4 1929

20. Undertaker T E Drake
Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68106

PLACE OF DEATH
County of Twin Falls
City of Hollister

Registration District No. 37
Primary Registration District No. 2085
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Rosa L. Nelson

(a) Residence. No. Hollister St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

48B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 3/1871

7. AGE 58 Years Months — Days 9 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer George Kindew

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER Geo. Kindew
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgia
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant John Nelson
(Address) Hollister

15. Filed 10-21-, 1929 [illegible] Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h~~er~~ ~~alive~~ on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Myo Carditis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sudden death (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unattended
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) F. E. Drake Coroner, M.D.
....., 19..... (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial Oct 13 1929

20. Undertaker F. E. Drake
Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68107

PLACE OF DEATH
County of Twin Falls
City of " " R.F.D.

Registration District No.
Primary Registration District No.
(No. R.F.D. # 2)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Elzina Curtiss

90

(a) Residence. No. Twin Falls R.F.D. # 2 St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 23 1855

7. AGE Years 74 Months 5 Days 22 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10. NAME OF FATHER George Wallbridge
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Mary Drake
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y.

14. Informant R. F. Bush
(Address) Twin Falls R.F.D. # 2

15. Filed 10-21-, 1929. D. D. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8, 1929, to Oct 15, 1929
that I last saw her alive on Oct 15, 1929
and that death occurred, on the date stated above, at 7 A m.
The CAUSE OF DEATH* was as follows:
Aortic incompetency and mitral incompetency - cardiac dilation
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H. W. Claudek M. D.
Oct 15, 1929. (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane Wash
Date of Burial 19

20. Undertaker J. J. Grossman
Address Twin Falls

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68108

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.

(No.) Lamb
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wm F Moss
(a) Residence. No. 720 Ale Str St. Died in Center Hospital 201
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) March 27/1879
7. AGE Years 50 Months 8 Days 2 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER W E Moss
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Daling Grich
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant H L Moss
(Address) Burley Idaho
15. Filed 11-6, 1929 Dr. J M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 29 (Month) (Day) 19 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 29, 1924, to Oct 24, 1924
that I last saw him alive on Oct 24th, 1924
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:
Fracture of skull and laceration of brain substance - auto accident in Twin Falls (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? accident
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? clinically
(Signed) H E Lamb M. D.
Oct 24, 1924 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal View Cemetry Date of Burial Nov 1 1929
20. Undertaker F C Drake Address Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED, APR 8- 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68108

Dr. H.E. Lamb
Twin Falls, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Wm. F. Moss who died at Twin Falls, Idaho on Oct. 29, 1929
Cause of death given as "Fracture of skull and lowation of brain substance."

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO PLEASE STATE WHERE THE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

He was struck by an automobile producing a fractured skull and lowerated his brain producing death in about one hour. It occured in Twin Falls, Ida on the main part of town

Dr H. E. Lamb

MAR 30 1981
FEB 6 1981
APR 30 1981

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68110

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

74B

2. FULL NAME Geo. F. Urie
(a) Residence. No. Hospital St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 10 1845

7. AGE Years 84 Months 3 Days 8. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS
10. NAME OF FATHER: Thomas Urie
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Mary Fulton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Frank Urie
(Address) Twin Falls

15. Filed 11-5-29, 19 Dr. D. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 18 1929 Dr Weaver
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct. 18, 1929
that I last saw him alive on Oct. 17, 1929
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:
Cerebral thrombosis
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Arterio-sclerosis
(duration) many yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. D. Weaver M. D.
10/22, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Teler Date of Burial: Oct 19 1929

20. Undertaker: F. C. Drake Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68111

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Frank P. Tindel
(a) Residence. No. Filer St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White Single
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years: 70 Months: — Days: — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: F E Drake Coroner
(Address) Twin Falls

15. Filed 11-5-29, 1929 Dr D. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 on Oct 15, 1929
that I last saw him alive on Oct. 15, 1929
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterio-sclerosis
(duration) (2) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. D. Weaver M. D.
10/17, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer
Date of Burial: Oct 17 1929

20. Undertaker: F E Drake
Address: Twin Falls

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68112

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.) Hospital 184 C

2. FULL NAME Barnes J. Cutler
(a) Residence. No. 1461 Addison St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): May 14 1860
7. AGE: Years 69 | Months 5 | Days 3 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Iowa
PARENTS
10. NAME OF FATHER: Thaddeus Cutler
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N Y
12. MAIDEN NAME OF MOTHER: Elyra Bumble
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ind
14. Informant: Floyd Cutler
(Address) Confined by the Sea Coast
15. Filed 11-5, 1929 Dr. D. Ks. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 17 1929 (Month) (Day) (Year) On Cremation
17. I HEREBY CERTIFY, That I attended deceased from 10-12, 1929, to 10-17, 1929
that I last saw h. alive on 10-17, 1929
and that death occurred, on the date stated above, at 8, 30 A m.
The CAUSE OF DEATH* was as follows:
Contra Croque Neuralgia
Bronc Fracture of Skull
Gets Addiction
Twin Falls Idaho (duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) 0
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? C
Did an operation precede death? No Date of C
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) John M. Coughlin M. D.
10-23, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Oct 21 1929
20. Undertaker: F. E. Drake — Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68113

Local Registrar's No. .....

2. FULL NAME V A Daniels

(a) Residence. No. Wendel St. Hospital

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Oct 5 1895

7. AGE: 34 Years | Months: — | Days: 19 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: F P Daniels

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Emma Stanley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Emma Stanley Daniels

(Address): Filer

15. Filed 11-5-, 1929 Dr. D. M. Courgill Registrar

MEDICAL CERTIFICATE OF DEATH Lamb

16. DATE OF DEATH: Oct 24 (Month) 6-30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22th, 1929, to Oct 24, 1929

that I last saw him alive on Oct 24th, 1929

and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Gangrenous bowel following obstruction of the ileum

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary): Appendicitis

(duration) ..... yrs. 3 mos. ..... ds.

18. Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Oct 22

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H C Lamb M. D.

Oct 24th, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer | Date of Burial: Oct 27 1929

20. Undertaker: F E Dick | Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68114

PLACE OF DEATH

County Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1080

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lorenzo Torrez

(a) Residence. No. Second South St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years — Months 9 Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work — — —

(b) General nature of industry, business, or establishment in which employed (or employer) — — —

(c) Name of employer — — —

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Lorenzo Torrez

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico

12. MAIDEN NAME OF MOTHER Addie Lamphrie

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill

14. Informant Addie Lamphrie
(Address) Twin Falls

15. Filed 10-21, 1929. Dr. D. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1929, to Oct 1, 1929

that I last saw him alive on dead Oct 1, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Intestinal Flue

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? General

(Signed) F. C. Drake Coroner M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls — Date of Burial Oct 4 1929

20. Undertaker F. C. Drake — Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

PLACE OF DEATH

County Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 31

Primary Registration District No. 2080

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68115

Local Registrar's No. .....

2. FULL NAME Ruel S Courtnay

(a) Residence. No. Rout 2 Twin Falls St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 13/1906

7. AGE Years 23 Months — Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER L S Courtnay

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wash

12. MAIDEN NAME OF MOTHER Mabel Bray

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Michigan

14. Informant L S Courtnay
(Address) Twin Falls

15. Filed 10-21-, 1929 Dr. D. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8, 1929, to Oct 9, 1929

that I last saw him alive on Oct 9, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrage - apoplexy.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) H. W. Clouchel, M. D.

Oct 9, 1929 (Address) Twin Falls, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Date of Burial Oct 12. 1929

20. Undertaker F. E. Drake Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68116

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clarance Jr. Yahne

(a) Residence. No. Kimberly St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 9/1928

7. AGE Years / Months — Days / If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER J C Yahne

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oklahoma

12. MAIDEN NAME OF MOTHER Hazel Bennett

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant J C Yahne

(Address) Kimberly

15. Filed 10-21 1929 Dr. Dr. M. Cowell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 10 1929 (Month) (Day) (Year) 9-30

17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Oct 10, 1929

that I last saw him alive on Oct 9, 1929

and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis with diarrhoea.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Tooth abscess

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J E Langenwalter, M.D.

Oct 10, 1929 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls | Date of Burial Oct. 1929

20. Undertaker F E Drake | Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68117

PLACE OF DEATH

County of Twin Falls

City of

Registration District No. 37

Primary Registration District No. 2080

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wm David Gurwell

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Widower

6. DATE OF BIRTH (month, day and year): Oct 13 1854

7. AGE: Years 75 Months 0 Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Cyrus Gurwell

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Don't Know

14. Informant: Mrs Robert Cooke
(Address)

15. Filed 10-21, 1929. Dr. D. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 5:00 A m.

The CAUSE OF DEATH* was as follows: Mitral regurgitation with myocarditis & cardiac decompensation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Probable coronary embolus (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Coroner's investigation & clinical history from physician

(Signed) George C. Halley, M. D.
Deputy Coroner

Oct 15, 1929 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls, Ida — Date of Burial: 10-19 1929

20. Undertaker: White Mortuary — Address: Twin Falls

RECEIVED OCT 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68118

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087

Local Registrar's No.

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Barbara Buchan

(a) Residence. No. ..... St. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 13 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Buchan

6. DATE OF BIRTH (month, day and year): Dec. 3 - 1855

7. AGE: Years 74 | Months 9 | Days 27 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Tatay, Bohemia

PARENTS

10. NAME OF FATHER: Dank Knaus
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Bohemia
12. MAIDEN NAME OF MOTHER: Dank Knaus
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bohemia

14. Informant: Mrs Barney Wilson
(Address): Buhl Idaho

15. Filed 10/30 1929 J. H. Humphrey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 20 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 1929 to Sept 30 1929 that I last saw h... alive on Sept 28 1929 and that death occurred, on the date stated above, at 1:15 m.

The CAUSE OF DEATH* was as follows:
Chronic valvular Heart disease
(duration) 2 yrs. 1 mos. ... ds.
CONTRIBUTORY (Secondary) Oedema of Lungs
(duration) ... yrs. ... mos. 2 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. H. Hagerman M. D.
10-1- 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation,~~ or Removal: Chicago Ill. | Date of Burial: ✓ 19
20. (Undertaker) L. E. Chesnut | Address: Buhl Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68119

PLACE OF DEATH

County of Twin Falls
City of Burley

Registration District No. 39
Primary Registration District No. 2087

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

44B

2. FULL NAME Bernard Sarlar

(a) Residence. No. 1717 Bannock St St.
(Usual place of abode)
Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Jennie Sarlar

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	46	7	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work merchant
(b) General nature of industry, business, or establishment in which employed (or employer) merchandise
(c) Name of employer own business

9. BIRTHPLACE (city or town) (State or country) Lebedoff Russia

PARENTS

10. NAME OF FATHER Isaac Sarlar
11. BIRTHPLACE OF FATHER (city or town) (State or Country) same
12. MAIDEN NAME OF MOTHER Sarah Steinman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) same

14. Informant Tho F Rodger
(Address) Boise Ida

15. Filed 10-21, 1929 J. W. Wingfield Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9- (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-20, 1929, to 9-20, 1929
that I last saw ~~him~~ alive on 9-20, 1929
and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:
Chron. myo carditis with acute dilatation

(duration) Few minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) Chron. myo carditis
probable (duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Boise, Ida.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Geo. Jennings, M. D.
9-20-, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal	Date of Burial 19
Boise Idaho	

20. Undertaker	Address
L. D. Johnson	Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68129

PLACE OF DEATH
County of Twin Falls
City of Burley
Registration District No. 39
Primary Registration District No. 2087
Local Registrar's No.
(No. 5)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Burton Henry McCauley

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Esther McCauley

6. DATE OF BIRTH (month, day and year): Sept. 9th. 1878.

7. AGE: Years: 52; Months; Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Easterbury Pa.

PARENTS

10. NAME OF FATHER: William McCauley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Dont Know.
12. MAIDEN NAME OF MOTHER: Sarah Thompson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pa.

14. Informant: Mrs Esther McCauley
(Address): Burley Idaho

15. Filed Nov. 7, 1929. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 25 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ by phone, 1924, to 25 October, 1929, that I last saw him alive on 12 October, 1929, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:
Sarcomatous growth at base of brain
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~
Did an operation precede death? No Date of ~
Was there an autopsy? No
What test confirmed diagnosis? X ray

(Signed) H. W. MacManus, M. D.
2 Nov, 1929 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burley Idaho — Date of Burial: Oct. 31 1929
20. Undertaker: [illegible] — Address: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68121

PLACE OF DEATH
County of Twin Falls
City of Twin Falls County Hospital

Registration District No. 39
Primary Registration District No. 2087
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

113

2. FULL NAME Iola Hecker

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Feb 4th 1929

7. AGE Years ✓ Months 8 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Buhl Ida

PARENTS
10. NAME OF FATHER Edw. E. Hecker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Eureka Calif
12. MAIDEN NAME OF MOTHER Edith Jackson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Thomasboro Ill

14. Informant Edw. E. Hecker
(Address) Buhl Ida

15. Filed 10-26 ✓, 1929. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. ✓ 22nd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/20, 1929, to 10/22, 1929
that I last saw her alive on 10/22, 1929
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Diarrhoea and enteritis
..... (duration) ..... yrs. (2) mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) C. D. Weaver, M. D.
10/24, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Ida. Date of Burial 10/24 ✓ 1929

20. Undertaker L. J. Johnson Address Buhl Ida

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68123

PLACE OF DEATH
County of Twin Falls
City of Twin Falls County Hospital

Registration District No. 39
Primary Registration District No. 2087
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

162

2. FULL NAME Not Named

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓ ✓

6. DATE OF BIRTH (month, day and year) Oct. 10th 1929

7. AGE Years ✓ Months ✓ Days ✓ If LESS than 1 day, 15 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Twin Falls County General Hospital

PARENTS
10. NAME OF FATHER Chester Hobson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Sarah Bristow
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tennessee

14. Informant Chester Hobson
(Address) Buhl Ida

15. Filed 10-12, 1929. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-10, 1929, to 10-11, 1929
that I last saw her alive on 10-11, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Organic Heart Failure in closing of Foramen ovale.
..... (duration) 15 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
..... (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Ko Jennings, M. D.
10-11-, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl, Ida
Date of Burial 10/12 1929

20. Undertaker L. J. Johnson
Address Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68124

PLACE OF DEATH
County of Twin Falls
City of Rasworth

Registration District No. 39
Primary Registration District No. 2087
(No.) 101a
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Joseph. W. Savelberg
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Savelberg

6. DATE OF BIRTH (month, day and year) Sept 4 - 1851

7. AGE Years 78 Months 1 Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Holland

PARENTS
10. NAME OF FATHER W. J. Savelberg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Dont Knaw
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Harry H Savelberg
(Address) Rasworth

15. Filed 10-7, 1929. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 6th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-6-, 1929, to 10-6, 1929
that I last saw him alive on 10-6-, 1929
and that death occurred, on the date stated above, at 7 a.m. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Geo. Jennings, M. D.
10-7-, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Ida. Date of Burial Oct-8th 1929

20. Undertaker L. J. Johnson Address Buhl Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68125

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Helen Hruska

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 2 1837

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
92	0	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Czecho Slovakia

PARENTS
10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant John Kanicek
(Address) Buhl Ida

15. Filed 10-5, 1929. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 - 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-20, 1929, to 10-4-, 1929
that I last saw her alive on 10-4-, 1929
and that death occurred, on the date stated above, at 12 a. m.
The CAUSE OF DEATH* was as follows: Myocardial Pneumonia

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) No. Jennings M. D.
10-5-, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl Cemetery	Oct 6 1929
20. Undertaker	Address
Waverly D Rupp	Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 1—Rev. 1919

RECEIVED NOV 16 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 15

Primary Registration District No.

File No. 68126

Registered No.

1. PLACE OF DEATH

County of Valley

City of Cascade (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sam B Packwood 1848

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	~~(Write the word.)~~

6. DATE OF BIRTH: Apr. 11 — 1901
(Month) (Day) (Year)

7. AGE: 28 Yrs. 6 Mos. 15 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brakeman R.R.
(b) General nature of industry, business or establishment in which employed (or employer): Railroading O.S.L. Ry.

9. BIRTHPLACE (State or Country): Ellensburg, Wash.

10. NAME OF FATHER: O.P. Packwood

11. BIRTHPLACE OF FATHER (State or Country): Ellensburg - Wash.

12. MAIDEN NAME OF MOTHER: Elizabeth Bradshaw

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth Packwood
(Address) Route 3. Parma, Idaho

15. Filed Oct 27 1929 Stella Carr
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 26th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1929 to Oct 26 1929 that I last saw h~~is~~ alive on Oct 26 1929 and that death occurred on the date stated above, at 4:55 P.M.

The CAUSE OF DEATH* was as follows:

Accidental death
Caused by crushing through abdomen between railroad cars

(Duration) 0 Yrs. 0 mos. 0 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Roscoe C Allard M. D.
10/27 1929 (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa, Idaho. DATE OF BURIAL 19

20. UNDERTAKER: H. McBratney ADDRESS Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A-25 M. 1-19

RECEIVED NOV 16 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

88B

File No. 68127

Registered No.

1. PLACE OF DEATH

County of Valley

City of South Fork of Salmon

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Noble Hamilton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 9 (Day) 1857 (Year)

7. AGE: 78 Yrs. 9 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Prospecting & Farming

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Wesley B. Hamilton

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Byers

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Asbery Hamilton

(Address) Yellow Pine, Ida

15. Filed ..... 19 .....

Stella Cain
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19 ....., to ..... 19 ....., that I last saw h..... alive on ..... 19 ....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) 1 Yrs. 0 mos. 0 ds.

Contributory (Secondary) Senility

(Duration) 2 yrs. 0 mos. 0 ds.

(Signed) A. D. Robb Coroner Valley Co. Ida M. D.

..... 19 ..... (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: South Fork of Salmon Hamilton Ranch

DATE OF BURIAL: Sept 29 1929

20. UNDERTAKER

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 18 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Washington
City of Cambridge

Registration District No. 88
Primary Registration District No. 2164
(No. ....., ... St.)

File No. 68128
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucinda A Bradlove

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widdow

6. DATE OF BIRTH. Aug (Month) 1 (Day) 1864 (Year)

7. AGE 65 Yrs. 2 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Amos Hankins

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Sarah Beavers

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C C Hankins
(Address) Silvies Oregon

15. Filed 10-17-29 191 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-1-28 191..., to 10-16- 1929, that I last saw her alive on 10-16-29 191..., and that death occured on the date stated above, at 9:30 A M.
The CAUSE OF DEATH* was as follows:
Carcinoma Left Breast.

(Duration) 1 Yr. ..... mos. ..... ds.
Contributory (Secondary) Marasmus
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
19..... (Address) [illegible] Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida
DATE OF BURIAL: 10/16 1929

20. UNDERTAKER: J A Fridelson
ADDRESS: Cambridge Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 24854

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

68129

DO NOT WRITE IN THIS SPACE

State File No. 68129

Registration District No. 23

Primary Registration District No. 2150

(No. L. D.)

Local Registrar's No. 19

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Mayre Tully

(a) Residence. No. 168 A St. 47

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: John F. Tully

6. DATE OF BIRTH (month, day and year): July 16 1869

7. AGE: Years 60 Months 3 Days 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Manti - Utah

PARENTS

10. NAME OF FATHER: Peter Marker

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Emily Elizabeth Harriman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salt Lake City, Utah

14. Informant: Mrs Carl Baker

(Address) Salt Lake City - Utah

15. Filed Oct 22, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 20 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6, 1929, to Oct 20, 1929

that I last saw her alive on Oct 19, 1929

and that death occurred, on the date stated above, at 5:00 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Left Breast

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Diabetes Mel.

(duration) 7 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Apr 22-29

Was there an autopsy? No

What test confirmed diagnosis? Biopsy - Urinalysis etc

(Signed) [signature] M. D.

Oct 22, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Rose Hill Cemetery Idaho Falls — Date of Burial: Oct 23 1929

20. Undertaker: C. C. Buck — Address: Idaho Falls Idaho

68130

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68130

PLACE OF DEATH

County of Twin Falls

City of " "

Registration District No. 37

Primary Registration District No. 2085

Local Registrar's No.

(No. Co. Gen. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Tom Tokayama

(a) Residence. No. Buhl Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

126

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Jap.

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Dont know

7. AGE: Years: About 51 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cook at Cafe

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Carl Koto.

9. BIRTHPLACE (city or town) (State or country): Japan

PARENTS

10. NAME OF FATHER: Dont know

11. BIRTHPLACE OF FATHER (city or town) (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Tom Koto
(Address) Twin Falls Ida

15. Filed 10-21-, 1929. Dr. D. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 1929, to Oct 5th, 1929 that I last saw him alive on Oct 5th, 1929 and that death occurred, on the date stated above, at 2:15 A m.

The CAUSE OF DEATH* was as follows:

Peritonitis Acute (Lesser Peritoneal Cavity.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Perforating Ulcer Stomach

(duration) yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Buhl. Ida.

Did an operation precede death? Yes Date of Oct 2nd

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Operation

(Signed) Duncan L. Alexander, M. D.

10/7/29, 19 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls | Date of Burial: Oct 7 1929

20. Undertaker: P. J. Grossman | Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

68131

RECEIVED NOV 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68131

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5697

90

2. FULL NAME William Kerkos

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Greek
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 22-1895

7. AGE Years 34 Months 8 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Restaurant Man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Greece

PARENTS
10. NAME OF FATHER Gust Kerkos
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Greece
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Greece

14. Informant John Pattis
(Address) Pocatello Idaho

15. Filed 11/20, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Nov 10, 1929
that I last saw him alive on Nov 10, 1929
and that death occurred, on the date stated above, at 11 a. m.
The CAUSE OF DEATH* was as follows:
Cardio Vascular. Renal Disease.
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C P Grasm, M. D.
11/15/29, 19.. (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt View Cemetery — Date of Burial Nov 17th 1929

20. Undertaker Schumacher & Beasley — Address Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

68132

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68132

PLACE OF DEATH
County of Ada
City of Eagle

Registration District No. 8
Primary Registration District No. 2004
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 88

183

2. FULL NAME Charles Stanley Witte
(a) Residence. No. Eagle, Idaho. ~~St.~~
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 16, 1912.
7. AGE Years 17 Months 3 Days 5 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Alliance Nebr.

PARENTS
10. NAME OF FATHER George A Witte
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Margaret Evans
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant George A Witte
(Address) Eagle Idaho

15. Filed 11-23, 1929 W. H. Rhodes Registrar
R. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 21, 1929.
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ ~~, to~~ ~~, 19~~ ~~that I last saw h~~ ~~alive on~~ ~~, 19~~ ~~and that~~ death occurred, on the date stated above, at about 11.40 A m.
The CAUSE OF DEATH* was as follows: Accidently shot himself in head with 25 Caliber Automatic Colts Revolver. causing death instantly. (duration) yrs. mos. ds.
~~CONTRIBUTORY~~ (Secondary) No Inquest. (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of —
Was there an autopsy? No.
What test confirmed diagnosis? —
(Signed) Co McBrahey, Coroner ~~M.D.~~
11/23/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Nampa Idaho. Date of Burial Nov. 27 29
20. Undertaker Summers & Krebs Address Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

68134

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68134

PLACE OF DEATH

County of Boise

~~City of Idaho~~ Precinct of Lowman, Idaho

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alex Tetzner

(a) Residence. No. Idaho City, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White, German

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 55 Years | Months: ✓ | Days: ✓ | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Miner & laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Fire fighter U.S. Forest Service

(c) Name of employer: United States Forest Service

9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10. NAME OF FATHER: Tetzner

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Gus Schlosser
(Address) Idaho City Idaho

15. Filed Nov. 29, 1929 C K Macey State Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 2nd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No doctor, 19, to, 19

that I last saw h alive on, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: As nearly as could be determined by the Coroner the cause of death was apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? no test

(Signed) H A Schlosser, M. D.
August 5th 1929 (Address) Coroner Idaho City, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho City, Idaho | Date of Burial: Aug 5th 1929

20. Undertaker: None | Address

68135

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68135

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 37

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth S. Linn 92
(a) Residence. No. Seattle Wash. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow
5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of A. A. Linn
6. DATE OF BIRTH (month, day and year) Nov 23 1862
7. AGE Years 66 Months 11 Days 1 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS
10. NAME OF FATHER J. C. Skuler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Mary C. Parker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant J. C. Keeler
(Address) Payette Ida.
15. Filed Oct 24 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 24 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 24, 1929, to Oct 24, 1929
that I last saw her alive on Oct 24, 1929
and that death occurred, on the date stated above, at 9:30 P. m.
The CAUSE OF DEATH* was as follows:
Probably Thrombosis of Coronary arteries (duration) few hours yrs. mos. ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? None
(Signed) Merrill R. Fox M. D.
Oct 25, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Seattle Wash. Date of Burial Oct 28 1929
20. Undertaker Glenn C Sandin Address Payette Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC[illegible] DEC 6 1929

68136

DO NOT WRITE IN THIS SPACE
State File No. 68136

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 92

(No. U. S. Veterans' Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Earl E. BURAU

(a) Residence. No. 90 Notus, Idaho St. Notus, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. x yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emily Burau

6. DATE OF BIRTH (month, day and year) July 7, 1891

7. AGE	Years	Months	Days	If LESS than 1 day,
	38	4	23	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS

10. NAME OF FATHER Edward Burau

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn.

12. MAIDEN NAME OF MOTHER Eva M. Small

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn.

14. Informant M. Cornelius

(Address) U.S.Vet.Bureau, Boise, Idaho.

15. Filed 11-30, 1929 W. H. Rhodes Registrar
R.B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 23, 1929, to November 30, 1929

that I last saw h[illegible] im alive on November 30, 1929

and that death occurred, on the date stated above, at 5:10 A.M. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) V.H.D. Mitral insufficiency Myocarditis and Influenza

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? xx

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? xx

(Signed) H. C. Smith, Reg.Med.Off., M. D.

11-30-29, 19 (Address) U.S.V.B. Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Parma, Idaho. Date of Burial: Shipped 12/1/29 19

20. Undertaker: Wm McBurney Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

68137

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
68137
State File No.

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 317

(No. Room 214 Noble Bldg. Dr. Lay's Office.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Earl H. Roberts. 90

(a) Residence. No. 1308 W. 21st street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Winifred Roberts.

6. DATE OF BIRTH (month, day and year) January 19th 1883

7. AGE Years	Months	Days	If LESS than 1 day, ~~hrs.~~ or min.
46	10	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Owner Bristol barber shop.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10. NAME OF FATHER Fred F. Roberts.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Bertha Taylor.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant Mrs. E. H. Roberts.

(Address) Boise, Idaho.

15. Filed 12-6-, 1929 W. N. Rhodes Registrar
A. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 2nd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~, ~~to~~ ~~, 19~~ ~~that I last saw h~~ alive on ~~, 19~~ ~~and that~~ death occurred, on the date stated above, at 6:50 P.M m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency
Chronic Nephritis
Embolus in left ventricle.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic splenitis
? (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes by Dr. Hawkins

What test confirmed diagnosis? Autopsy

(Signed) Harold Wilson, M. D.

12/6/29, 19 (Address) Boise, Idaho.

D. McBratney, Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	12/5/29. 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

68138

DO NOT WRITE IN THIS SPACE

State File No. 68138

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

89

2. FULL NAME John J. Connery

(a) Residence. No. Portland St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): not known

7. AGE: about 48 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: solisiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Twin Falls Times

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: F.E.Drake County Coroner
(Address) Twin Falls Idaho

15. Filed 11-23rd, 1929. Dr David M. Cowgill
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 10/29 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1929, to Nov 10, 1929

that I last saw him alive on Nov 10, 1929

and that death occurred, on the date stated above, at unable to state

The CAUSE OF DEATH* was as follows:

Angina pectoris - examined him 8 P.M. Nov 10 - at my office he suffering from angina pectoris - returned to his room at Rogerson Hotel where he was found dead the next day. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) H W Clanchett M. D.

Nov 11, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shipped to Portland | Date of Burial: 19

20. Undertaker: F.E.Drake | Address: Twin Falls

RECEIVED DEC 9 1929

68139

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68139

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 157

(No. 179)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henrietta Strait

(a) Residence. No. N. 4th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	Widow

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of A. B. Strait

6. DATE OF BIRTH (month, day and year) 1863-1-14

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	9	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iron River Wis.

PARENTS
10. NAME OF FATHER —
11. BIRTHPLACE OF FATHER (city or town) (State or Country) France France
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) France

14. Informant Clemenza Dionne
(Address) N. 4th St

15. Filed Nov 29, 1929. N. L. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h[illegible] alive on —, 19—
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:
Burned to death when Service Station Caught fire
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) Harold J. Sturgis, M. D.
Nov. 27, 1929 (Address) CDA - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CDA	11-7 1929
20. Undertaker	Address
Cassedy Funeral Hme	CDA

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A-25M. 1-19

RECEIVED DEC 16 1929

68140

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68140

Local Registrar's No. -

1. PLACE OF DEATH

County of Fremont

City of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Rosser Jenkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH: October 25th, 1891 (Month) (Day) (Year)

7. AGE: 38 Yrs. XXXX Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): Associated Seed Co.

9. BIRTHPLACE (State or Country): Egin Bingham Co. Idaho

10. NAME OF Father: Ephriam W. Jenkins

11. BIRTHPLACE OF FATHER (State or Country): South Wales

12. MAIDEN NAME OF MOTHER: Catherine Davis

13. BIRTHPLACE OF MOTHER (State or Country): South Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ephriam W. Jenkins
(Address) St. Anthony, Idaho.

15. Filed Dec. 10th, 1929 19 — Dr. M. Hansen, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 18th, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10 1929 to Dec. 10, 1929 that I last saw him alive on Dec. 10, 1929 and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Bullett Wounds not inflicted by self (Dead about 3 hrs.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Homicide

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. M. Kelly M. D.

12/10 1929 (Address) St. Anthony, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Parker	Dec. 12th, 1929

20. UNDERTAKER	ADDRESS
Dr. M. Hansen	St. Anthony, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 22 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68140

Dr. P.M. Kelly
St. Anthony

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

B. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:
David Rosser Jenkins who died at St. Anthony, Idaho on Nov. 18, 1929
Cause of death given as "Bullet wounds not inflicted by self.

Information DESIRED in order to complete certificate:

WAS DEATH DUE TO HOMICIDE OR ACCIDENT?

PLEASE ANSWER BELOW: Please 10-20-30
Death Due to Homicide.
P. M. Kelly M. D.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. Rhodes

RECEIVED DEC 6 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68141

County of Ada.
City of Boise.

Registration District No. 3
Primary Registration District No. 1004
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 286

1013

2. FULL NAME Mrs. Byrl H. Smith.

(a) Residence. No. 719 N. 7th street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 21 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 7th 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	6	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerical
(b) General nature of industry, business, or establishment in which employed (or employer) Newspaper
(c) Name of employer Capital News Publishing Co.

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER William C. Hildebrand.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.
12. MAIDEN NAME OF MOTHER Julia Dettmer.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know.

14. Informant Harold H. Smith.
(Address) 719 N. 7th street. Boise, Ida.

15. Filed 11-2, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 29th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 12, 1927, to Oct 29, 1929
that I last saw her alive on Oct 29, 1929
and that death occurred, on the date stated above, at 5:45 P.M.
The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Tabes Dorsalis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical & chemical findings

(Signed) W. N. Rhodes Jr., M. D.
10/30/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	10/31/29 19

20. Undertaker	Address
Wm. McBratney;	Boise, Ida

RECEIVED OCT 23 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

68141

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Dr. Alfred Budge Jr.
Boise

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Mrs. Byrl H. Smith who died at Boise on Oct. 29, 1929
Cause of death given as "Hypostatic Pneumonis." "Tabes."

Information DESIRED in order to complete certificate:

PLEASE COMPLETE STATEMENT OF CAUSE. TABES DORSALIS?

PLEASE ANSWER BELOW:

Cause of death
Hypostatic Pneumonia
Contributory
"Tabes Dorsalis."

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68142

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 3
Primary Registration District No. 1004
Local Registrar's No. 287
(No. 320 East Jefferson Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Warren E. Richardson

(a) Residence. No. 320 East Jefferson St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louisa M. Richardson

6. DATE OF BIRTH (month, day and year) March 8th 1849

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	7	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter & Contractor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) West Milton, Ohio.

PARENTS

10. NAME OF FATHER William W. Richardosn.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Hester Jones.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Mrs. Rex Flenner.
(Address) Boise, Idaho.

15. Filed 11-2, 1929 W. H. Rhodes Registrar
R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to Nov 1, 1929
that I last saw h. alive on Oct 31, 1929
and that death occurred, on the date stated above, at 3:50 A.M. m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Cystitis.
(duration) yrs. 5 mos. ds.

18. Where was disease contracted if not at place of death? Don't know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Urinary Exam.

(Signed) C. S. Allen, M. D
11/1/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2 whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	11/3/29 19
20. Undertaker Wm. McBratney.	Address Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68143

Dr. Ralph Falk
Boise

Dear Doctor:

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Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Ada May Anderson whodied at Boise, Idaho on Nov. 5, 1929
Cause of death given as "Pulmonary embolism."

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

please

Chronic salpingitis, right

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68143

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 10.04
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 288

2. FULL NAME Ida May Anderson

(a) Residence. No. 97 St. Midvale Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wht.
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Rufus Anderson

6. DATE OF BIRTH (month, day and year): May 13 - 1894

7. AGE: Years 35 | Months 5 | Days 22 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): So Dakota

PARENTS
10. NAME OF FATHER: John Bergman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: No Record
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): No Record

14. Informant: Rufus Anderson
(Address): Midvale, Ida

15. Filed 11-6, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 5th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/14, 1929, to 11/5, 1929
that I last saw her alive on 11/5, 1929
and that death occurred, on the date stated above, at 8:30 A m.
The CAUSE OF DEATH* was as follows:

Pulmonary embolism
(duration) hours
CONTRIBUTORY (Secondary) Chronic cholecystitis
cholelithiasis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 10/25-29
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Ralph Tate M. D.
11/6, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Midvale, Ida — Date of Burial: 11/7 1929
20. Undertaker: Schreiber & McCann — Address: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68144

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 291

(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

187

2. FULL NAME Harry Shaw.

(a) Residence. No. Portland, Oregon. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Don't know.

7. AGE: 50 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Don't Know.

PARENTS

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Pearl Allen.
(Address) Boise, Idaho.

15. Filed 11-12, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 9th 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1929, to Nov. 9, 1929
that I last saw him alive on Nov. 9, 1929
and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:
Traumatic Injuries to head and fracture of right femur.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accident & Injuries. Log struck back + st. side -
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Logging camp

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? post + x-rays.

(Signed) Herald T. Nokes, M. D.

10/9/20, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 11/13/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 5 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

68144

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Dr. H.T. Nokes
Boise

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Harry Shaw who died at Boise, Idaho on Nov. 9, 1929
Cause of death given as "Traumatic injuries to head and fracture of right femur."

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH?

PLEASE ANSWER BELOW:

Log Stacking individual on back and right side.

Henry T. Nokes.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE—IN THIS SPACE

State File No. 68145

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 004

Local Registrar's No. 292

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frederick Daniel Granholm

(a) Residence. No. 803 Hays St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rose C. Granholm.

6. DATE OF BIRTH (month, day and year) Nov. 13, 1846.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	11	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10. NAME OF FATHER Daniel Christain

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Marie Reimer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Robt. Newton

(Address) 702 Oregon St.

15. Filed 11-12 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1929 to Nov 9th 1929 that I last saw h— alive on Nov 9th 1929 and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of left submaxillary gland

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 1928

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Nov 12 1929
20. Undertaker	Address
Summers & Rhodes	Boise Ida

RECEIVED OCT 21 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68145

Dr. A. Goodfriend
Boise

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Fredrick Daniel Granholm who died at Boise, Idaho on Nov. 9, 1929
Cause of death given as "Carcinoma." of left and right Submaxillary Gland

Information DESIRED in order to complete certificate:

PLEASE STATE THE PRIMARY SEAT OF THE DISEASE.

PLEASE ANSWER BELOW:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68146

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 294

(No. 1521 Grove Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Sarah Fulton

(a) Residence. No. 1521 Grove St. 70
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Eber Fulton.

6. DATE OF BIRTH (month, day and year) December 7th 1863

7. AGE: 65 Years; Months: 11; Days: 5; If LESS than 1 day, ~~hrs. or~~ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ind.

PARENTS

10. NAME OF FATHER: John Ashmore.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Clark Co. Ill..

12. MAIDEN NAME OF MOTHER: Susan Meyers.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio.

14. Informant: Mrs. Susie Cantral.
(Address) Boise, Idaho.

15. Filed 11-13, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 12th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Nov 10th 1929, to Nov 12th, 1929 that I last saw her alive on Nov 10th, 1929 and that death occurred, on the date stated above, at 9 P.M. m.

The CAUSE OF DEATH* was as follows: Encephalitis - accompanied with dementia and heart lesions.-

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

11/13/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 11/14/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

RECEIVED DEC 6 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68147

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 295

(No. St. Alphonsus Hos.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marie Louise Hardenburgh

(a) Residence. No. 403 Franklin St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. ~~If married, widowed, or divorced~~
HUSBAND of (or) WIFE of Martin Julius Hardenburgh

6. DATE OF BIRTH (month, day and year) Feb 9th 1850

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	9 ~~0~~	4	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work X

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ulster Co-N.Y.-

PARENTS

10. NAME OF FATHER Cornelius C. Wynne

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ulster Co-

12. MAIDEN NAME OF MOTHER S. A. Boice

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ulster Co N.Y.

14. Informant Adelyn H. Feller
(Address) 403 Franklin St.

15. Filed 11-13-1929 W. F. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11/13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/11 1929 to 11/13 1929
that I last saw her alive on 11/13 1929
and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows: Cancer of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of 10/29-29
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Ralph Todd M. D.
11/13 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Shipwreck

19. Place of Burial, Cremation, or Removal	Date of ~~Burial~~
Kingston N. Y.	Nov. 15 1929
20. Undertaker	Address
Schneider & McLaun	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68148

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 296

(No. 1901 N. 29th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME A. J. Lambrigger.

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Flora Lambrigger.

6. DATE OF BIRTH (month, day and year): March 15th 1861

7. AGE: 68 Years | Months: 7 | Days: 25 | If LESS than 1 day, ---------- ins. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Illinois.

PARENTS

10. NAME OF FATHER: A. J. Lambrigger.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Swizerland.

12. MAIDEN NAME OF MOTHER: Anna

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Swizerland.

14. Informant: Mrs. Ernest Sacks.
(Address) Boise, Idaho.

15. Filed 11-15, 1929 W. H. Rhodes R. S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Found dead November 10th 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19 , to , 19~~ ~~that I last saw in alive on , 19~~ ~~and that~~ death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows: Found Dead. Chronic Heart Disease. Had been a sufferer of heart trouble for a long time (duration) yrs. mos. ds.

~~CONTRIBUTORY~~ (Secondary) Natural Cause No Inquest (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W. McBratney Coroner ~~M. D.~~

10/12/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Dry Creek Cemetery | Date of Burial: 11/16/29 19

20. Undertaker: Wm. McBratney. | Address: Boise, Ida.

Budget

RECEIVED DEC 6 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68149

County of Ada

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 297

(No. St. Alphonsus Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

H 6 R

2. FULL NAME Mrs. Vina Nichols.

(a) Residence. No. 1516 Colorado St. St.

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph Nichols.

6. DATE OF BIRTH (month, day and year) July 15th 1894

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35	4	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Green B. Emby.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Don't Know.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Joseph Nichols.

(Address) Boise, Idaho.

15. Filed 11-18 1929 W. H. Rhodes Registrar

R. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 16th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 3, 1929, to Nov 16, 1929

that I last saw her alive on Nov 16, 1929

and that death occurred, on the date stated above, at 11:15 P.M.

The CAUSE OF DEATH* was as follows: Carcinoma of the cervix

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes no Date of Apr 3 1929

Was there an autopsy?

What test confirmed diagnosis Clinical & Microscopical findings.

(Signed) Alfred Budge, M. D.

11/18/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	11/19/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68150

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 298

117

2. FULL NAME Joe Goecke
(a) Residence. No. ..... St. Bernard, Valley County
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 8-14-1857

7. AGE: 72 Years | Months: 2 mo. | Days: 28 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Prospector + miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Bunker Hill & Sullivan M & C Co.

9. BIRTHPLACE (city or town) (State or country): Westphalen, Germany

PARENTS

10. NAME OF FATHER: Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: J W Grimm
(Address): Cascade, Ida.

15. Filed 11-19, 1929 W. H. Rhodes R.E. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 5th, 1929, to Nov 12th, 1929
that I last saw him alive on Nov 12th, 1929
and that death occurred, on the date stated above, at 9 A. m.
The CAUSE OF DEATH* was as follows:

Ruptured appendix

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Coronary Thrombosis

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of Nov. 6/29.
Was there an autopsy? no.
What test confirmed diagnosis? operation
(Signed) J S Springer, M. D.
Nov 14th, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Johns Cemetery | Date of Burial: 11/15 1929

20. Undertaker: Schreiber & McCann | Address: Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68152

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No.) 94a
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 300

2. FULL NAME Addie E. Baker
(a) Residence. No. 1508 North 27th St. Ogden, Utah
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. — yrs. 1 mos. 7 days How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alvin D Baker

6. DATE OF BIRTH (month, day and year) July 31 - 1863

7. AGE Years 66 Months 3 Days 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Retired House Keeper
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER Isom Chanell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Am.
12. MAIDEN NAME OF MOTHER Marion Buck
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Am.

14. Informant Bert Baker
(Address) Ogden Utah

15. Filed 11-23, 1929 W. H. Rhodes Registrar
R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Nov 23, 1929
that I last saw her alive on Nov 22, 1929
and that death occurred, on the date stated above, at 7 30 A. m.
The CAUSE OF DEATH* was as follows: Paralytic stroke
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) High blood press — Ure, chronic malaria
(duration) 10 yrs. — mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical syncp
(Signed) W L Frazier, M. D.
11-23, 1929 (Address) 513 E. Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ogden, Utah
Date of Burial 11/24 1929

20. Undertaker Schreiber & McCann
Address Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1929

PLACE OF DEATH

County of Ada.

City of Boise.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 68153

Local Registrar's No. 301

161 R

2. FULL NAME Betty Jean Reedy.

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) November 23rd 1929

7. AGE: Years 0 | Months 0 | Days 2 | If LESS than 1 day, ---------- hrs. or ---------- min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise, Idaho.

PARENTS

10. NAME OF FATHER: Ralph Reedy.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho City, Idaho.

12. MAIDEN NAME OF MOTHER: Myrtle Wilton.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Boise, Idaho.

14. Informant: Ralph Reedy.
(Address): Boise, Idaho.

15. Filed 11-25, 1929 W. H. Rhodes Registrar
RS

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 25th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23rd, 1929, to Nov. 25, 1929
that I last saw h[illegible] alive on Nov. 25, 1929
and that death occurred, on the date stated above, at 12:20 P. m.

The CAUSE OF DEATH* was as follows:

Too low vitality - Premature
ly born

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Callaway Jaffis, M. D.
11/25/29, 19 (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 11/26/29 19

20. Undertaker: Wm. McBratney. — Address: Boise, Ida.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6154

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 302
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph I Singer

(a) Residence. No. 509 S 14 St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Maggie Singer

6. DATE OF BIRTH (month, day and year) Oct. 24-1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	0	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS
10. NAME OF FATHER John Singer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Charles Casey
(Address) Twin Falls Idaho

15. Filed 11-25-1929 W. F. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14, 1929, to Nov 23, 1929
that I last saw h alive on Nov 23, 1929
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
ulcer of stomach.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic myocarditis.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J A Springer, M. D.
Nov 25th, 1929 (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Joplin Cemetery	Nov 25 1929
20. Undertaker	Address
Summers & Kibbe	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68155

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 303

PLACE OF DEATH

County of Ada
City of Boise
(No. St. Alphonsus Hos.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Constance William Hease

(a) Residence. No. 1316 N 8th St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: mal
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena M Hease

6. DATE OF BIRTH (month, day and year): May 4, 1875

7. AGE — Years: 54 — Months: 7 — Days: 20 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: self.

9. BIRTHPLACE (city or town) (State or country): St Louis Mo.

PARENTS

10. NAME OF FATHER: Ernest H. Hease.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.
12. MAIDEN NAME OF MOTHER: Nina M Moberger
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): St Louis. Mo.

14. Informant: Ernest B Hease
(Address): Boise Ida

15. Filed 11-25 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 24th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1929, to Nov. 24th, 1929, that I last saw h— alive on Nov 24th, 1929, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Paranchymatous Nephritis.

(duration) 7 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Heart Block.

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis?

(Signed) [illegible] M. D.
Nov 26, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pioneer Cemetery	11/27 1929
20. Undertaker: Schreiber & McCann	Address: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68156

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004

Local Registrar's No. 304

(No. 716 - Franklin St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Catherine Truckey

(a) Residence. No. 716 - Franklin St.
(Usual place of abode)
Length of residence in city or town where death occurred. 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 17, 1861

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	67	7	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country) Cedarburg, Wisconsin

PARENTS

10. NAME OF FATHER John Hollihan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant George A. Truckey
(Address) 716 - Franklin St

15. Filed 11-26, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19, 1929, to Nov 25, 1929
that I last saw her alive on Nov 25, 1929
and that death occurred, on the date stated above, at 6 30 p.m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
Left sided hemiplegia
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Chronic Auricular Fibrillation
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. A. Forbsch, M. D.
Nov 26, 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Johns Cemetery	Nov. 27 1929
20. Undertaker	Address
Summers & Kuehn	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Dr. Falk

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68158

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 306

(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME John W. Field.

(a) Residence. No. Boise, Idaho. Route #2. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha M. Field.

6. DATE OF BIRTH (month, day and year) November 17th 1862

7. AGE: 67 Years, Months: 0, Days: 12. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming. (Retired.)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: Edmond Field

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Don't Know.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill.

14. Informant: Mrs. J. W. Field.

(Address) Boise, Idaho. mR#2.

15. Filed 11-30, 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 29th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/6, 1929; to 11/29, 1929

that I last saw him alive on 11/28, 1929

and that death occurred, on the date stated above, at 5 A.M. m.

The CAUSE OF DEATH* was as follows:

Uremia

Suprapubic cystotomy for hypertrophied prostate obstructing neck of bladder (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

Suprapubic cystotomy (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 11/18-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Labor

(Signed) [signature], M. D.

11/29/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 12/1/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68158

Dr. Ralph Falk
Boise

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

B. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

John W. Field who died at Boise on Nov. 29, 1929
Cause of death given as "Uremia. Myocarditis."

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Supra pubic cystotomy
for long standing prostate
obstructing neck of bladder

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68159

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Luke's)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 307

2. FULL NAME Myrtle Tilliland Stone

(a) Residence. No. 1723 Ada St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm S. Stone

6. DATE OF BIRTH (month, day and year) Nov. 4, 1896

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
33	—	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gore Okla

PARENTS

10. NAME OF FATHER L. A. Tilliland
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Arkansas
12. MAIDEN NAME OF MOTHER Hetty Parker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas

14. Informant Mrs. O. B. Stone
(Address) Meridian Idaho

15. Filed 11-30, 1929 W. T. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Nov 28, 1929
that I last saw her alive on Nov 28, 1929
and that death occurred, on the date stated above, at 1.20 A.M.
The CAUSE OF DEATH* was as follows:

Pernicious vomiting of pregnancy.
(duration) yrs. 3 mos. 15 ds.
CONTRIBUTORY (Secondary) Convulsions
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) O. B. Beach, M. D.
Nov 29, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Ida	11-29 1929

20. Undertaker E. W. Robson — Address Meridian Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

C. Borch

RECEIVED DEC 6 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68160

County of Ada.
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 308
(No. 912 Grove Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Nancy Cathrine Williams.

(a) Residence. No. 912 Grove Street. St. 44
(Usual place of abode)
Length of residence in city or town where death occurred. 3 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White.	Divorced.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Williams.

6. DATE OF BIRTH (month, day and year) January 29th 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	10	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Abingdon, Iowa
(State or country)

PARENTS

10. NAME OF FATHER David L. Huffstutter.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Harrison Co. Ind.
12. MAIDEN NAME OF MOTHER Martha E. Doughty.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rush Co., Ind.

14. Informant Mrs. Cliff.
(Address) Boise, Idaho.

15. Filed 11-30, 1929 W. N. Rhodes Registrar
A.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 29th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1929, to Nov 29, 1929
that I last saw h. alive on Nov 29, 1929
and that death occurred, on the date stated above, at 7 A.M. m.
The CAUSE OF DEATH* was as follows:

Cancer of stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) C. V. Borch, M. D.
11/29/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	12/1/29 19

20. Undertaker	Address
Wm. McBratney	Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

PLACE OF DEATH

County of Ada.

City of Boise.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68162

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 82

(No. Collister Stateion.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Cyrus V. Smith

(a) Residence. No. Collister Station, Boise St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia M. Smith.

6. DATE OF BIRTH (month, day and year) September 19th 1851

7. AGE: 78 Years | Months: 1 | Days: 17 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Mining Man.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Altoona, Pa.

PARENTS

10. NAME OF FATHER: Mathias Smith.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know.

12. MAIDEN NAME OF MOTHER: Jane Coleman.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Don't Know.

14. Informant: Mrs. Julia M. Smith.
(Address) Boise, Idaho.

15. Filed 11-7, 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 6th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from On Nov. 6, 1929, to , 19

that I last saw him alive on Nov 6, 1929

and that death occurred, on the date stated above, at 8 A.M/ m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Collister, M. D.

11/7/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 11/9/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68163

Registration District No. 5

Primary Registration District No. 2004

Local Registrar's No. 83

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David Vosburgh

49

(a) Residence. No. 4½ Mile N.W. of City Boise St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Wht.

5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Vosburgh

6. DATE OF BIRTH (month, day and year): Apr. 25 1872

7. AGE: Years 57, Months 6, Days 11. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Augusta Mich.

PARENTS

10. NAME OF FATHER: Edwin Vosburgh

11. BIRTHPLACE OF FATHER (city or town) (State or Country): No Record

12. MAIDEN NAME OF MOTHER: Ellen Romans

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mich.

14. Informant: Mrs. F. M. Tarr
(Address)

15. Filed 11-8, 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1928, to November, 1929 that I last saw him alive on November 27, 1929 and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Bladder

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Sept. 1929

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) Harold W. Stone M. D.

Nov. 6, 1929 (Address) Eastman Bldg. Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 11 8 1929

20. Undertaker: Schreiber & McCann — Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68164

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 84

(No. U. S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Francis R. JENNINGS

(a) Residence. No. Boise, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

100a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Louise Jennings

6. DATE OF BIRTH (month, day and year) 9-28-1897

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
32	1	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country): xx

12. MAIDEN NAME OF MOTHER: xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): xx

14. Informant: U. S. Veterans Bureau.
(Address) Boise, Idaho.

15. Filed 11-12, 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 9, 1929, to November 11, 1929 that I last saw him alive on November 11, 1929 and that death occurred, on the date stated above, at 1:05 A.M. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

xx (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Influenza

xx (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? xx

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? xx

(Signed) F.C.Smith, Reg.Med.Officer, M. D.
11-12-29, 1929 (Address) U.S.Vet.Bureau Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mount Ayr, Iowa. Date of Burial: Shipped 11/12/29 19

20. Undertaker: m. McBratney. Address: Boise, Idaho.

Brafton

RECEIVED DEC 6 1929

PLACE OF DEATH

County of Ada.

City of Boise.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No. Ada County Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 68165

Local Registrar's No. 85

2. FULL NAME Cyrus Pickens.

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

13-1

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Divorced.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) February 11th 1847

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	8	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Mining Man.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) W. Va.
(State or country)

PARENTS

10. NAME OF FATHER Don't Know.

11. BIRTHPLACE OF FATHER (city or town) " "
(State or Country)

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) "
(State or Country)

14. Informant Pearl Allen.

(Address) Boise, Idaho.

15. Filed 11-13, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 10th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1925, to Nov 10, 1929
that I last saw h~~e~~ alive on Nov 7, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Hypertrophied Prostate. Syphilis.

(duration) 4 yrs. 9 mos. 9 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 3 mos. 9 ds.

18. Where was disease contracted if not at place of death? Ada County
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) T. M. Brafton, M. D.
10/12/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	11/12/29 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

R. 2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68166

PLACE OF DEATH

County of Ada.

City of Barber

Registration District No. 5

Primary Registration District No. 2004

Local Registrar's No. 87

(No. Barber, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clara Elizabeth Donaldson.

(a) Residence. No. Barber, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) November 17th 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Barber, Idaho.

PARENTS

10. NAME OF FATHER Laurence P. Donaldson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Winnipeg, Canada.

12. MAIDEN NAME OF MOTHER Alice Harryman.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas.

14. Informant L. P. Donaldson.
(Address) Barber, Idaho.

15. Filed 11-18, 1929 W. H. Rhodes Registrar
R. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 17th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17th, 19--, to Nov 17th, 1929
that I last saw her alive on Nov 17th, 1929
and that death occurred, on the date stated above, at 7 P.M. m.
The CAUSE OF DEATH* was as follows

Malformations of Spine

died of convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

11/18/29 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	11/18/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68167

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 89
(No. U.S.V. Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Andrew J. KIMES

(a) Residence. No. (Usual place of abode) Blanchard, Idaho St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. X yrs. 2 mos. X ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of XX

6. DATE OF BIRTH (month, day and year) 6-5-1846

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	5	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work XX
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER XX

11. BIRTHPLACE OF FATHER (city or town) (State or Country) XX

12. MAIDEN NAME OF MOTHER XX

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) XX

Ohio

14. Informant M. Cornelius
(Address) U.S. Veterans' Bureau, Boise, Idaho

15. Filed 11-26, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 25, 1929, to November 24, 1929
that I last saw him alive on November 24, 1929
and that death occurred, on the date stated above, at 12:22 A.m.

The CAUSE OF DEATH* was as follows:
Auricular Fibrillation
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? XX
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy & Laboratory

(Signed) F. C. Smith, Reg. Med. Officer M. D.
11-26-29, 1929 (Address) U.S.V. Bureau Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spirit Lake, Idaho — Date of Burial: Shipped 11/26/29 19

20. Undertaker: Wm. McC. Bratney — Address: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1929

PLACE OF DEATH

County of Ada.

City of Near Boise.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2,024

(No. 19 Miles Southwest of Boise,)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 68168

Local Registrar's No. 90

2. FULL NAME J. C. Schultz.

(a) Residence. No. 19 Miles Southwest of Boise. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 17th 1861

7. AGE	Years	Months	Days	If LESS than 1 day, ~~hrs.~~ or ~~min.~~
	68	3	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Davenport, Iowa.

PARENTS

10. NAME OF FATHER J. H. Schultz.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Mary Hansen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Mrs. J. C. Schultz.

(Address)

15. Filed 11-27-29, 19 W. D. Rhodes Registrar

K.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 25th 1929, 19
(Month). (Day). (Year).

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ , 19 , to , 19

~~that I last saw him~~ alive on , 19

~~and that~~ death occurred, on the date stated above, at about 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Had a fall causing injury to abdomen. Obstruction of Bowels following, lasting 4 Days. Gases and fluids backing up into stomach causing death.

CONTRIBUTORY (Secondary) abdominal and thoracic cavities greatly distended (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W. McBratney, Coroner, ~~M. D.~~

11/27/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cemetery, Nampa, Idaho.	11/27/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Ida.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68169

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 81

(No. 74a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Annie D. McClintock

(a) Residence. No. 12 Miles West of Boise on Valley road
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 19 1881

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	3	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Grant Lee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Roy McClintock
(Address) Eagle Idaho R 2 B 1

15. Filed 11-6, 1929 W. H. Rhodes Registrar
R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1920, to Nov 5, 1929
that I last saw h alive on Nov 3. dead Nov 5, 1929
and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage June 1929
High blood pressure 5 years.
Removal of gall bladder
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Embolism coronary atery 2 hours
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? removal of gall bladder.
Did an operation precede death? Yes. Date of Aug.
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) H M Halverson, M. D.
, 19 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Nov. 7 1929
20. Undertaker	Address
Summers & Krebs	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 21 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

68169

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Dr. H.M. Holverson
Boise

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

B. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Annie D. McClintock who died at Boise on Nov. 5, 1929
Cause of death given as "Cerebral Hemorrhage June 1929. High blood pressure 5 years."

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Removal of gall bladder by Dr Stone

RECEIVED DEC 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68170

PLACE OF DEATH
County of Ada
City of Starr

Registration District No. 9+10
Primary Registration District No. 9+10
Local Registrar's No. 1

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME Flossia Mary Heater

(a) Residence. No. Starr Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days: ~~3~~ | If LESS than 1 day, 26 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Starr Idaho.

PARENTS

10. NAME OF FATHER Dewey S. Heater
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Macon Mo
12. MAIDEN NAME OF MOTHER Nora. O. Plaster
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kan City Mo

14. Informant Dewey S. Heater
(Address) Star Idaho

15. Filed 11/5, 1929. Orvie Jackson Registrar
Eagle Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-4, 1929, to 11-5, 1929
that I last saw her alive on 11-4, 1929
and that death occurred, on the date stated above, at 7 A. m.
The CAUSE OF DEATH* was as follows:
Reoperation Foramen Ovale.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) H. F. Neal, M. D.
11-5, 1929 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Star Ida | Date of Burial: 11-5 1929

20. Undertaker: B. W. Robison | Address: Meridian Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 21 [illegible]

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68172

Local Registrar's No. 5696

100a

2. FULL NAME Bobbie Eugene Britthart.

(a) Residence. No. 1028-E Custer - 9 St. North St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6. DATE OF BIRTH (month, day and year)

7. AGE: ✓ Years: ✓ Months: 3 Days: ✓ If LESS than 1 day, ✓ hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9. BIRTHPLACE (city or town) (State or country): Sada Springs, Ida.

PARENTS

10. NAME OF FATHER: Chester Britthart

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Dora Dawson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pocatello Idaho

14. Informant: Mrs. C. Britthart
(Address) 1028-E. Custer

15. Filed 11/14, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6, 1929, to Nov 14, 1929 that I last saw him alive on 11-13, 1929 and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH* was as follows: Bronchial pneumonia

..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary): Measles

..... (duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D C Ray, M. D.

11-14, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello - Idaho — Date of Burial: Nov. 16 1929

20. Undertaker: H. L. McHan — Address: Pocatello Ida

RECEIVED NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68173

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

(No. Poca. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5695

1610

2. FULL NAME Infant Hynes

(a) Residence. No. Poca. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 9, 1929.

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	0	0	Three hrs. or ____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER W. J. Hynes

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Chicago, Ill.

12. MAIDEN NAME OF MOTHER Augusta Spillman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pocatello, Idaho.

14. Informant W. J. Hynes

(Address) Victor, Idaho.

15. Filed 11/12, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 9, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/9, 1929, to 11/9, 1929
that I last saw her alive on 11/9, 1929
and that death occurred, on the date stated above, at 1/9 m.
The CAUSE OF DEATH* was as follows: Premature 6 Mos

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Suppurative Appendicitis the mother -

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Victor Ida

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. R. Young M. D.

11/12, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	11/10/29. 19

20. Undertaker Arthur W. Hall Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 21 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2 8

Primary Registration District No. 2 1 6 1

(No. Poca. General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 68174

Local Registrar's No. 5694

2. FULL NAME Mary Ann Hawkes

(a) Residence. No. 486 St. Ashton, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 19, 1920.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	9	1	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Student

(c) Name of employer At School

9. BIRTHPLACE (city or town) (State or country) Ashton, Idaho.

PARENTS

10. NAME OF FATHER A. S. Hawkes

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Franklin, Idaho.

12. MAIDEN NAME OF MOTHER Marion Higginbotham

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ogden, Utah.

14. Informant Mrs. A. S. Hawkes

(Address) Ashton, Idaho.

15. Filed 11/10, 1929 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 9, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929, to Nov. 9, 1929
that I last saw her alive on Nov. 8, 1929
and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis—
mitral regurgitation—marked
dilation Heart

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Infected Tonsils

(duration) ... yrs. 10 mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J. Hughart, M. D.

11/9, 1929 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Drummond, Idaho.	On Arrival 19

20. Undertaker Arthur W. Hall Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 21 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
- BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 24

Primary Registration District No. 2141

(No. General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68275

Local Registrar's No. 5693

2. FULL NAME Isabell A Olson

(a) Residence. No. Virginia St. 126

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6. DATE OF BIRTH (month, day and year): July 24-1916

7. AGE — Years: 13 — Months: 3 — Days: 15 — If LESS than 1 day, hrs. or min.:

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home & School.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Virginia Idaho

PARENTS

10. NAME OF FATHER: Emil A. Olson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Afford Idaho

12. MAIDEN NAME OF MOTHER: Annie Gooch

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Afford Idaho.

14. Informant: Emil A Olson

(Address): Virginia Idaho

15. Filed 11/10, 1929 — H. Young — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-7, 1929, to 11-9, 1929

that I last saw her alive on 11-9, 1929

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

General peritonitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Perforated appendix

(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Virginia Ida.

Did an operation precede death? Yes Date of 11/7/29

Was there an autopsy? Yes by Drs. Hartung & Dee

What test confirmed diagnosis? —

(Signed) [signature] M. D.

11/9, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Afton Wyo Crm — Date of Burial 19

20. Undertaker: Arthur W Hall. — Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68176

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 26
Primary Registration District No. 2601

Local Registrar's No. 5692

(No. 1010) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frances Margaret Grumpert

(a) Residence. No. 923 E. Sanders St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept 25-1874

7. AGE: Years 55 | Months 1 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Halden Missouri

PARENTS

10. NAME OF FATHER: John J. Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Anna Hayhurst
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa or Ohio

14. Informant: Ike Grumpert
(Address): Pocatello Idaho

15. Filed 11/6, 1929 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-1, 1929, to 11-3, 1929
that I last saw her alive on 11-3, 1929
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
(duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) ..... yrs. ..... mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible], M. D.
11-6, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View	Nov 7 1929
20. Undertaker	Address
Thomas & Beasley	City

RECEIVED NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6817

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 569
(No. St Anthony)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward W. Knittel

(a) Residence. No. 131 St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Tena Knittel

6. DATE OF BIRTH (month, day and year) Feb 12 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10. NAME OF FATHER William Knittal
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant Mrs E W Knittel
(Address) Aberdeen, Ida

15. Filed 1/4, 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1929, to Nov 4, 1929
that I last saw him alive on Nov 4, 1929
and that death occurred, on the date stated above, at 11:45 A m.
The CAUSE OF DEATH* was as follows:
Uraemia following
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Prostatectomy
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Nov 1-1929
Was there an autopsy? No What test confirmed diagnosis? Clinical Symptoms
(Signed) A M. Newton M. D.
Nov 4, 1929 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Aberdeen, Idaho	11/6/29

20. Undertaker Anderson Address American Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68178

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5690

(No. Rear 535 - No. Main St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jerome B. Bradley

(a) Residence. No. 535 - No. Main St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn Story

6. DATE OF BIRTH (month, day and year) Aug. 28, 1860

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	2	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Moroni, Utah

PARENTS

10. NAME OF FATHER George Bradley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Elizabeth Love
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Mrs. Jerome B. Bradley
(Address) 535 - N - Main St. Pocatello.

15. Filed 11/2, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 1, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Nov 1, 1929
that I last saw him alive on Oct, 1929
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows: Cardio Renal disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. H. Young, M. D.
11/2, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moreland, Idaho.	11/4/29
20. Undertaker	Address
Arthur W. Hall	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68179

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5688

2. FULL NAME John Robert Gregoire
(a) Residence. No. ..... St. 126
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July 2-1924

7. AGE: Years 5, Months 3, Days 27. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Pocatello Ida

PARENTS

10. NAME OF FATHER: Geo. H. Gregoire
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pocatello Ida
12. MAIDEN NAME OF MOTHER: Josephine Robison
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Geo. H. Gregoire
(Address): Pocatello, Ida

15. Filed 11/6, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-26, 1929, to 10-29, 1929
that I last saw him alive on 10-29, 1929
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows:
Streptococcic peritonitis
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary): Streptococcic pharyngitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Lab. finding
(Signed) [signature] M. D.
11/6, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View
Date of Burial: Oct 30 1929

20. Undertaker: Schumacher & Beasley
Address: City

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 21 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ramsey — Registration District No. 28

City of Pocatello — Primary Registration District No. 2101

(No. ..... St.)

File No. 68180

Registered No. 5687

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Criswell Shubzuggs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 28 (Day) 1929 (Year)

7. AGE: ..... Yrs. 14 hours Mos. ..... ds.

IF LESS than 1 day how many 13 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Lynn Mass

10. NAME OF FATHER: John C. Shubzuggs

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Alma L. Keller

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John C Shubzuggs

(Address) Fairview Idaho

15. Filed 10/30 1929 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28, 1929, to Oct 29 1929, that I last saw him alive on Oct 29 1929, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Blue Baby

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Forceps Delivery

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Lynn M. D.

10-29-1929 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fairview Idaho	Oct 30 1929
20. UNDERTAKER	ADDRESS
Schumacher & Beasley	Cary

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6818

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 25
Primary Registration District No. 2101
Local Registrar's No. 5686
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Walker

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 24, 1929.

7. AGE Years	Months	Days	If LESS than 1 day,
0	0	0	Six hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None, Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Ida.

PARENTS

10. NAME OF FATHER Melvin H. Walker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rockland, Idaho.
12. MAIDEN NAME OF MOTHER Cassie A. Jensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Brigham City, Utah.

14. Informant Melvin H. Walker
(Address) 923 East Lander St. Poca. Ida.

15. Filed 10/29, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 25, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24, 1929, to Oct 25, 1929
that I last saw h alive on Oct 24, 1929
and that death occurred, on the date stated above, at 2 p m.
The CAUSE OF DEATH* was as follows:

Premature birth
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Toxic goitre of mother with albuminuria
..... (duration) ..... yrs. 3 mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) W. W. Ritchey M. D.
10-29, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rockland, Idaho.	10/25/29.
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68182

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. POCATELLO GENERAL HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3689

1610

2. FULL NAME EDNA ELIZABETH WALKER

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): SINGLE

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) OCT. 24, 1929

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
0	0	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: NONE
(b) General nature of industry, business, or establishment in which employed (or employer): INFANT
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): POCATELLO, IDA.

PARENTS

10. NAME OF FATHER: MELVIN H. WALKER
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ROCKLAND, IDAHO.
12. MAIDEN NAME OF MOTHER: CASSIE A. JENSEN
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): BRIGHAM CITY, IDA.

14. Informant: MELVIN H. WALKER
(Address): POCATELLO, IDAHO.

15. Filed 11/4, 1929 — J. M. Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) - 30 (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-24, 1929, to 10-30, 1929, that I last saw her alive on 10-30, 1929, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Premature Twin

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Toxic goitre & albuminuria in mother.

..... (duration) ..... yrs. 6 mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) W. W. Brothers, M. D.
10-31, 1929 (Address) Pocatello Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
ROCKLAND, IDAHO.	10/31/29 19
20. Undertaker	**Address**
ARTHUR W. HALL	POCATELLO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68183

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello Gen Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5685

2. FULL NAME Anna McVay

(a) Residence. No. 241 Taft ave St. 129
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 17. 1859

7. AGE Years 70 Months 7 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): House keeper
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS
10. NAME OF FATHER: W. F. Watkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Catherine Fry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs Paul Gerhart
(Address) 241 Taft ave. Pocatello

15. Filed Oct 22 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19, 1929, to Oct 21, 1929, that I last saw her alive on Oct 21, 1929, and that death occurred, on the date stated above, at 3,35 P. m.

The CAUSE OF DEATH* was as follows:
Cardio Renal Disease
Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature], M. D.
10/22, 1929. (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Ida
Date of Burial: Oct 24 1929

20. Undertaker: McHan Undt Co.
Address: Pocatello

RECEIVED NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68184

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5684

PLACE OF DEATH

County of Bannock
City of Pocatello
(No. Residence North of City)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Buddy Lamar Kynaston

(a) Residence. No. Residence North of City St. 119
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	S.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) March 29 - 1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS

10. NAME OF FATHER Vaughn Kynaston
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hatch Idaho
12. MAIDEN NAME OF MOTHER Malba Hansen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Louisville Idaho

14. Informant Vaughn Kynaston
(Address) Pocatello

15. Filed 10/21, 1929. J R Cheney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-17, 1929, to 10-19, 1929
that I last saw h— alive on 10-19, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Infected Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J R Cheney M. D.
10/21, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cem	Oct 21 1929
20. Undertaker	Address
Anthony W Hall	Poca

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 21 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68185

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5683

(No. St Anthony Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George W Robinson

45

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Jan. 5 876

7. AGE: 53 Years | Months: 6 | Days: 13 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: School Teacher.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10. NAME OF FATHER: Joseph Duncan Robinson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Sarah Black

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa.

14. Informant: Mrs Ella Robinson
(Address) Idaho Falls Ida

15. Filed 19/18, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13, 1929, to Oct 18, 1929, that I last saw him alive on Oct 17, 1929, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Transverse Colon—Decending Colon with involvement of greater portion of the small intestine (duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary): Same

..... (duration) ..... yrs. 8 mos. ..... ds.

18. Where was disease contracted if not at place of death? Idaho Falls Id.

Did an operation precede death? Yes Date of Oct 15-29

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) [signature] M. D.

Oct 19, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Springfield Ida | Date of Burial: Oct 20 1929

20. Undertaker: Cliff Hayes | Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 21 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68186

Local Registrar's No. 5682

2. FULL NAME Jesus Balensula

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Mexican

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6. DATE OF BIRTH (month, day and year)

7. AGE: 65 Years, Months, Days: about, If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Extra going laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Oil Ry.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mexico

PARENTS

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): —

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): —

14. Informant: General Hosp.
(Address) Pocatello

15. Filed 10/21, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 16, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-1, 1929, to 10-16, 1929

that I last saw h..... alive on 10-16, 1929

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows: Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? [signature]

(Signed) [signature] M. D.

10/21, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Ida — Date of Burial: Oct 21 1929

20. Undertaker: McHan Undt Co — Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68191

PLACE OF DEATH

County of Bannock

City of ~~Pocatello~~ McCammon

Registration District No. 84

Primary Registration District No. 2161

Local Registrar's No. 167

(No. Residence East of McCammon)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Gittins Sr

(a) Residence. No. Residence 4 miles East of McCammon St. 164
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Roberts

6. DATE OF BIRTH (month, day and year): October 4 - 1829

7. AGE: Years 99, Months 8, Days 2. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: George Gittins

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England.

12. MAIDEN NAME OF MOTHER: Mary Randles

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England.

14. Informant: John J Gittins
(Address) McCammon

15. Filed Nov. 30, 1929. Mrs G. G. Fitz, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st 1929, to Nov 1st 1929 that I last saw him alive on June 6, 1929 and that death occurred, on the date stated above, at 1:45 a.m.

The CAUSE OF DEATH* was as follows: Old age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. A. Kirk, M. D.

6-7-, 1929 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: McCammon Cemetery — Date of Burial: June 8 1929

20. Undertaker: Arthur W. Hall. — Address: Pocatello

FORM V. S. No. 5-25 M. 1-19.

REC... DEC 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cannock

City of Robin

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. ..... St.)

File No. 68192

Registered No. 168

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Parrish Burton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 22 (Day) 1855 (Year)

7. AGE: 74 Yrs. 7 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Kaysville Utah

10. NAME OF FATHER: Robert Walton Burton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Marriott

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Burton

(Address) Robin Ida By C A Rich

15. Filed Nov 30 1929 Mrs G. G. Fit
Local Registrar

MEDICAL CERTIFICATE OF DEATH

44

16. DATE OF DEATH: October (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 9, 1929 that I last saw him alive on Oct 8 1929, and that death occurred on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver & stomach (carcinomata)

(Symptomatic Diagnosis)

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) Old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Rich M. D.

10-9 1929 (Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED NOV 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68193

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 55
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

2. FULL NAME Grant Lawrence Stewart

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 27, 1907

7. AGE Years 22 Months 9 Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) St Charles Idaho
(State or country)

PARENTS

10. NAME OF FATHER J. L. Stewart
11. BIRTHPLACE OF FATHER (city or town) St Charles Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Emma E Matthews
13. BIRTHPLACE OF MOTHER (city or town) St Charles Idaho
(State or Country)

14. Informant Mrs J. L. Stewart
(Address) St Charles Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Acute Myocarditis
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Over Exertion Mt. Climbing.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Laketown Utah
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Findings
(Signed) C O Moore M. D.
10/30, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St Charles Idaho
Date of Burial Oct 1 1929

20. Undertaker [illegible]
Address Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68194

PLACE OF DEATH
County of Bear Lake
City of Bloomington

Registration District No. 53
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 128

101a

2. FULL NAME Mrs. Sarah Jane Bridwell Dunford
(a) Residence. No. Bloomington Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed Mr. Moroni Dunford
6. DATE OF BIRTH (month, day and year) May 21 1865
7. AGE Years 64 Months 5 Days 29 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) August Georgia
PARENTS
10. NAME OF FATHER Thomas Jefferson Bridwell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Sarah Little
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)
14. Informant T. J. Dunford
(Address)
15. Filed 11-25, 1929 Mrs J. S. Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 20 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1929 to Nov. 20, 1929
that I last saw her alive on Nov. 20, 1929
and that death occurred, on the date stated above, at 7:30 a m.
The CAUSE OF DEATH* was as follows: Bilateral lobar pneumonia
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Consolidation (dullness) rales at base of both lungs. Leprosy fever, cyanosis.
(Signed) Spencer H. Pick M. D.
Nov. 22, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bloomington Idaho Date of Burial Nov. 23 1929
20. Undertaker F. M. Williams Address Ida Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68195

PLACE OF DEATH

County of Benewah Registration District No. 32

City of St. Maries, Ida Primary Registration District No. 2019

Local Registrar's No. 33

(No. St. Maries Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Charles Brunsiakle

(a) Residence. No. 18½ Main St. Spokane Wn
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 35 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Logging Camp

(c) Name of employer: Blackwell Lumber Co

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country):

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Dr. C. A. Robins
(Address): St. Maries, Ida

15. Filed Nov 30, 1929 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1929, to Nov 10, 1929

that I last saw him alive on Nov 10, 1929

and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, (broncho-)
(secondary to burns sus-
tained at night when he attempted
to relight fire with kerosene (duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Extensive burns (accidental)
of all degrees (duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death? Burned at logging camp

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam

(Signed) C A Robins M. D.

11/11, 1929 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Maries Ida	Nov 16 1929
20. Undertaker	Address
Geo B Mitchell	St Maries

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED DEC 11 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Benewah

City of St. Maries

Registration District No. 32

Primary Registration District No. 2049

(No. St. Maries Hospital)

File No. 68196

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas E. Kirkpatrick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widowed

6. DATE OF BIRTH. Mar (Month) 12 (Day) 1849 (Year)

7. AGE 80 Yrs. 8 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R V Kirkpatrick

(Address) St Maries

15. Filed Nov 30 1929 Walter Boberg Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 13th 1929 (Month) (Day) (Year) 164

17. I HEREBY CERTIFY, That I attended deceased from Aug 9 1929, to Nov 13 1929, that I last saw him alive on Nov 12 1929, and that death occured on the date stated above, at 8:35 A.M.

The CAUSE OF DEATH* was as follows:

Senility -

(No definite disease entity ascribable)

(Duration) 2 Yrs. / mos. ds.

Contributory (Secondary) Benign Hypertrophy of Prostate (Duration 2 yrs. mos. ds.

(Signed) C A Robins M. D.

11/13 1929 (Address) St Maries, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 83 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? unknown

Former or usual residence St Maries, Idaho

19. PLACE OF BURIAL OR REMOVAL: St Maries Idaho

DATE OF BURIAL: Nov 17 1929

20. UNDERTAKER: Geo E Mitchell

ADDRESS: St Maries

SYMS - YORK CO., PTRS. & SDRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68197

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 35

2. FULL NAME Catherine Lena Bailey 44
(a) Residence. No. 332 - 11th St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: O E Bailey

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 63 Months 11 Days 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): McComb Ill

PARENTS
10. NAME OF FATHER: Wm Charon
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Amanda Michael
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N C

14. Informant: Mrs James Bailey
(Address) St Maries

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16, 1929, to Nov 18, 1929
that I last saw her alive on Nov 17, 1929
and that death occurred, on the date stated above, at 8 a m.
The CAUSE OF DEATH* was as follows: Carcinoma of liver - probably primary in pancreas.
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No —
What test confirmed diagnosis?
(Signed) D Cornwall, M. D.
Nov 21, 1929 (Address) St Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries Ida
Date of Burial: Nov 20 1929

20. Undertaker: Geo E Mitchell
Address: St Maries

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED DEC 11 1929

1. PLACE OF DEATH

County of Benewah

City of Tensed

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 68158

Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Verner Richard Storms

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6. DATE OF BIRTH. Dec (Month) 5 (Day) 1909 (Year)

7. AGE .....Yrs.....Mos.....ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Contractor Logging
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Troy Idaho

10. NAME OF FATHER Andrew J. Storms

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Ruth E. Osterberg

13. BIRTHPLACE OF MOTHER (State or Country) Troy Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew J. Storms
(Address) N 4323 Adams St.

15. Spokane Wash.
Filed Nov 30 1929 Walter Boberg
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 183 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows: accidental gun shot

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) J. Fispe M. D.

11-23 1929. (Address) Coroner

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Spokane Wash

DATE OF BURIAL 11-26 1929

20. UNDERTAKER C. L. Schulerud

ADDRESS Tekoa Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68199

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. City Jail)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 37

128

2. FULL NAME Unknown

(a) Residence. No. Tacoma Wn St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Nigro
5. Single, Married, Widowed, or Divorced (write the word): Unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years: about 60 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Wm Steele, Chief of Police
(Address) St.

15. Filed Nov 30, 1929 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/22/29, 19, to 11/22, 1929
that I last saw him alive on 11/22, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
acute nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) G. Gespe Coroner, M. D.
11/23, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Maries, Ida | Date of Burial: 11-26 1929

20. Undertaker: Geo E Mitchell | Address: St Maries

FORM V. S. No. 5-25 M. 1-16-13 RECEIVED DEC 13 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bennewah

City of Dr Smet

Registration District No. 31

Primary Registration District No.

(No. ....., ... St.)

File No. 68202

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alvin Benjamin Lasort

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Sept 21 1926 (Month) (Day) (Year)

7. AGE ..... Yrs. 3 Mos. 1 Mo. ds. 20

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Child

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Dr Smet Ida

10. NAME OF FATHER Alvin Lasort

11. BIRTHPLACE OF FATHER (State or Country) Montana

12. MAIDEN NAME OF MOTHER Theresa Rieke

13. BIRTHPLACE OF MOTHER (State or Country) Coeur d'Alene Reserve Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alvin Lasort

(Address) Dr Smet Ida

15. Filed Nov. 12 1929 John Post Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 11 22 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1929, to Nov 11 1929, that I last saw him alive on Nov 11 1929, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows: Acute Anterior Poliomyelitis

..... (Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Nelson M. D.

11/12 1929 (Address) Dekoa Wn.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Desmet, Idaho

DATE OF BURIAL: Nov. 13 1929

20. UNDERTAKER: Louis Luke

ADDRESS: Desmet, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24653

Current Complete. September 1929

RECEIVED DEC 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68203

PLACE OF DEATH

County of Ft. Hall Reservation,
City of Idaho.

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 185

162

2. FULL NAME Franklin Pohipe.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Shoshone Ind. 4/4
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6. DATE OF BIRTH (month, day and year) Feb. 6, 1929

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft. Hall Reservation

PARENTS

10. NAME OF FATHER Dewey Pohipe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemhi Reservation
12. MAIDEN NAME OF MOTHER Irene Honena
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lemhi Reservation

14. Informant Dewey Pohipe
(Address) Ft. Hall, Idaho.

15. Filed Nov. 10, 1929 Wm Walter E Catrine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 9, 1929 19..... (Month) (Day) (Year)
No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Cholera Infantum.

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Henry R. Wheeler M.D.
....., 19..... (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Butte Cemetery Ft. Hall Reservation — Date of Burial Sept. 12, 1929

20. Undertaker Agency Carpenter, Ft. Hall, Ida — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929

Current Complete September 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68204

PLACE OF DEATH

County of Ft. Hall Reservation
City of Idaho.

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 186

2. FULL NAME Bettie Besto.

(a) Residence. No. ..... St. 162
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Shoshone Ind. 4/4
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of -- -----

6. DATE OF BIRTH (month, day and year) March 2, 1929

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft. Hall Reservation

PARENTS

10. NAME OF FATHER Cornelius Besto
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fort Hall Reservation
12. MAIDEN NAME OF MOTHER Tena Pocatello
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ft. Hall Reservation

14. Informant Cornelius Besto.
(Address) Ft. Hall, Idaho.

15. Filed Nov. 10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 22, 1929 19
(Month) (Day) (Year)
No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Cholera Infantum.

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Henry R. Wheeler M. D.
....., 19..... (Address) Ft. Hall, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Cedar Hill, Cemetery Ft. Hall Reservation — Date of Burial Sept. 23, 29 19

20. Undertaker Agency Carpenter, Ft. Hall, Idaho — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929

Current Complete September 1929.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 03205

PLACE OF DEATH

County of Ft. Hall Reservation, Idaho.
City of
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 187
(No. 31)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minnie Violet Eagle.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Bannock Ind. 7/8	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James Eagle

6. DATE OF BIRTH (month, day and year) ---- 1905

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	24	--	--	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Inkom, Idaho.

PARENTS

10. NAME OF FATHER Louis Douglass

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ft. Hall, Idaho.

12. MAIDEN NAME OF MOTHER Minnie Jackson,

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Inkom, Idaho.

14. Informant Maline Edmo.
(Address) Ft. Hall, Idaho.

15. Filed Nov. 10, 19 29 Mrs Walter E. Eaton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 25, 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1, 19 29, to Sept. 25, 1929, 19
that I last saw her alive on Sept. 24, 1929, 19
and that death occurred, on the date stated above, at 9: P m.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) ----

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ----
Did an operation precede death? None Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) Henry G. Wheeler, M. D.
19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Presbyterian Mission, Ft. Hall, Idaho. Sept. 28,	1929 19
20. Undertaker	Address
Brown, Eldredge, Blackfoot,	Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929

Current Complete

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

September 1929.

DO NOT WRITE IN THIS SPACE
State File No. 68206

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ft Hall Reservation, Idaho

City of

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 188

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME Theodore Edmo.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Shoshone Ind. 7/8

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) -- 1913

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
16	--	---	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ft. Hall Reservation,

PARENTS

10. NAME OF FATHER: Willie Edmo

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ft. Hall Reservation

12. MAIDEN NAME OF MOTHER: Elsie Mink

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ft. Hall Reservation

14. Informant: Elsie Edmo.
(Address) Ft. Hall, Idaho.

15. Filed Nov. 10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 28, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1924, to Sept. 28, 1929, 19

that I last saw him alive on Sept. 25, 1929, 19

and that death occurred, on the date stated above, at 8:P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) 5 yrs. 8 mos. 25 ds.

CONTRIBUTORY (Secondary) ------

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ----

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) Henry R. Cohales, M. D.

, 19 (Address) Ft. Hall, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Portneuf Cemetery, Ft. Hall Reservation — Date of Burial: 10, 1, 1929 19

20. Undertaker: Brown-Eldredge, Blackfoot — Address: Idah o

Current Complete September 1929.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED DEC 10 1929

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68207

County of Ft. Hall Reservation, Idaho

City of

Registration District No. I2I

Primary Registration District No. 2I94

Local Registrar's No. 189

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucile Sambo. 31

(a) Residence. No. ---------- St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fenale

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: George Sambo

6. DATE OF BIRTH (month, day and year): I882

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
47	---	---	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ft. Hall Reservation

PARENTS

10. NAME OF FATHER: Tom Waterhouse

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ft. Hall Reservation

12. MAIDEN NAME OF MOTHER: Yambaropy

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ft. Hall Reservation

14. Informant: Mrs. Tom Waterhouse.
(Address) Ft. Hall, Idaho.

15. Filed Nov. IO, 1929 Mrs Walter E. Catrine
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 29, I929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. I, 1929, to Sept. 29, 1929 that I last saw her alive on Sept. 29, I929 and that death occurred, on the date stated above, at 4:A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs.

(duration) I yrs. -- mos. ds.

CONTRIBUTORY (Secondary) ----

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ----

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Henry R. Cokeler, M. D.

, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Portneuf Cemetery, Ft. Hall Reservation, IO-2-I929 — Date of Burial 19

20. Undertaker: Brown-Eldredge, Blackfoot, Idaho — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68208

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 190

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alfred Lewis Hess

(a) Residence. No. Blackfoot RF 02 St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 21 1928

7. AGE: Years 1, Months 2, Days 17; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Babe
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): St Anthony Idaho

PARENTS

10. NAME OF FATHER: Earl Hess
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Cambridge Nebraska
12. MAIDEN NAME OF MOTHER: Birdie V. Wynn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Oaklahoma

14. Informant: Earl Hess
(Address): Blackfoot Idaho R 2

15. Filed Nov. 8, 1929 McWalter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7, 1929, to Nov 7, 1929
that I last saw him alive on Nov 7, 1929
and that death occurred, on the date stated above, at 1:30 A m.
The CAUSE OF DEATH* was as follows:
Celulitis of neck
(duration) — yrs. — mos. 2 ds.
CONTRIBUTORY (Secondary): Infected wound of lip - child fell injuring lip on gravel road (duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W W Beck, M. D.
11/8, 1929 (Address) Blackfoot, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Green City Cemetery — Date of Burial: Nov. 9th 1929

20. Undertaker: E T Peck — Address: Blackfoot Ida

RECEIVED OCT 22 1930

PUBLIC-HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68208

Dr. W.W. Beck
Blackfoot

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

B. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Alfred Lewis Hess who died at Blackfoot, Idaho on Nov. 8, 1929
Cause of death given as "Celulitis of neck. Infected wound of lip."

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH.

PLEASE ANSWER BELOW:

Child fell injuring lip on gravel road.

W W Beck M.D

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68210

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2174
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 192

160

2. FULL NAME Carrol Lynn Morgan

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 2, 1929

7. AGE Years — Months — Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Blackfoot
(State or country) Idaho

PARENTS

10. NAME OF FATHER Carrol E. Morgan
11. BIRTHPLACE OF FATHER (city or town) Iowa
(State or Country)
12. MAIDEN NAME OF MOTHER Fern Lynn
13. BIRTHPLACE OF MOTHER (city or town) Wyoming
(State or Country)

14. Informant Carrol E. Morgan
(Address) Blackfoot Ida

15. Filed Nov. 11, 1929 Mrs Walter E. Potvin
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1929, to Nov 10, 1929
that I last saw him alive on Nov 10, 1929
and that death occurred, on the date stated above, at 2:30 P.m.
The CAUSE OF DEATH* was as follows:

Icterus Neonatorum

..... (duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Premature birth
7½ mo
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W W Beck, M. D.
11/10, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Grove City Cem. | Date of Burial Nov. 11. 29. 19

20. Undertaker Modern Mortuary | Address Blackfoot. Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68211

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 193

2. FULL NAME James Noah Miller
(a) Residence, No. 727 E. Judicial St. 48B
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband of Alice Sarah Miller

6. DATE OF BIRTH (month, day and year): March 16, 1866

7. AGE: Years 63, Months 7, Days 29. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Cedar Rapids, Iowa

PARENTS

10. NAME OF FATHER: Frank Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Sarah Chamberlin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Emily S. Kirkpatrick
(Address) 727 E. Judicial Blackfoot Ida

15. Filed Nov. 18, 1929 McWalter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 16 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Nov 15, 1929, to ....., 19....
that I last saw him alive on Nov 15, 1929
and that death occurred, on the date stated above, at 10.15 A. m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis with Chronic nephritis
..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical findings
(Signed) J. O. Harrington, M. D.
11-18, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Grove City Cemetery
Date of Burial: 19

20. Undertaker: E. J. Peck
Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68212

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 194

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

124

2. FULL NAME Francisca Hernandez.

(a) Residence. No. Blackfoot. Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE:
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sep. 17. 1927

7. AGE: Years 2 | Months 2 | Days 0 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot. Ida

PARENTS

10. NAME OF FATHER Paul Hernandez

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico

12. MAIDEN NAME OF MOTHER Jernoima Hernandez

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico.

14. Informant Paul Hernandez
(Address) Blackfoot. Ida.

15. Filed Nov 18, 1929 Wm Walter Catine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 17. 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Nov 16, 1929
that I last saw her alive on Nov. 16, 1929
and that death occurred, on the date stated above, at 6:30 A. m.
The CAUSE OF DEATH* was as follows:

Acute Hepatitis

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) F. W. Mitchell, M. D.
11/18, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City. Cem
Date of Burial: Nov. 18. 29 19

20. Undertaker: Modern Mortuary
Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68213

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 131
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 195

2. FULL NAME George H White

74a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Dec 15 1858

7. AGE: Years 70 | Months 11 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wiscasset Main

PARENTS

10. NAME OF FATHER: James White
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Main
12. MAIDEN NAME OF MOTHER: Lucilla Lowell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Main

14. Informant: Mrs G. H. White
(Address) Blackfoot Ida

15. Filed Nov 19, 1929 Mrs Walter E. Cabin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1, 1929, to November 18, 1929
that I last saw him alive on November 18, 1929
and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows:

Central Apoplexy

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) F. W. Mitchell, M. D.
11/18, 1929 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Grove City Cemetery
Date of Burial 19

20. Undertaker: E F Peck
Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68214

PLACE OF DEATH

County of Bingaham
City of Blackfoot.

Registration District No. 121
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 196

2. FULL NAME Dorthy Jane Marshall

(a) Residence. No. No. Univ. St. 70
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June, 8, 1926

7. AGE: Years 3 | Months 5 ~~10~~ | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot. Ida

PARENTS

10. NAME OF FATHER Clifford P. Marshall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Franklin Ida
12. MAIDEN NAME OF MOTHER Sarah C. Orchard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lewistonm Utah. ~~Idaho.~~

14. Informant Clifford P Marshall
(Address) Blackfoot.Ida.

15. Filed Nov 20, 1929, Wm Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 18. 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30, 1929, to Nov 18, 1929
that I last saw her alive on Nov 18, 1929
and that death occurred, on the date stated above, at 3:00 P m.
The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) \ yrs. \ mos. 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W W Beck, M. D.
11/19, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or ~~Removal~~: Lewiston, Utah. | Date of Burial: 11-21-29 19

20. Undertaker: Modern Mortuary, Blackfoot.Ida | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68215

PLACE OF DEATH
County of Bingham
City of Blackfoot.

Registration District No. 121
Primary Registration District No. 2144

Local Registrar's No. 197

(No. 20-a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hugh Lynn Grimmett

(a) Residence. No. Moreland. Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May. 20. 1929.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Moreland Ida.
(State or country)

PARENTS

10. NAME OF FATHER Garden E. Grimmett

11. BIRTHPLACE OF FATHER (city or town) Moreland
(State or Country)

12. MAIDEN NAME OF MOTHER Vera Thompson

13. BIRTHPLACE OF MOTHER (city or town) Wyo.
(State or Country)

14. Informant G E Grimmett
(Address) Moreland

15. Filed Nov. 21, 1929 W. McClellan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 19. 1929.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:
No Physician in attendance.

Pbobably Pneumonia
(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Roy McClellan Coroner of Bingham Co., Ida.
Nov. 21. 29 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~	Date of Burial
Moreland cemetary	Nov.22,29.19
20. Undertaker	Address
None	

RECEIVED DEC 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68216

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 198

(No. Dr. Dora France Hospital- County Hospital.
(If death occurred in a hospital or institution, give its name instead of street and number) 320 w. Judicial St

2. FULL NAME Malvina Gagnon.

(a) Residence. No. 609 North University St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mose Gagnon, deceased.

6. DATE OF BIRTH (month, day and year): Dec. 27, 1872

7. AGE: Years 56, Months 10, Days 24. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Montreal, Canada.

PARENTS

10. NAME OF FATHER: Amable Pilon.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): St. Janier. Canada.

12. MAIDEN NAME OF MOTHER: Arrelie Gratton.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): St. Janier, Canada

14. Informant: Anna Gagnon
(Address) Blackfoot Idaho

15. Filed Nov 23, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 21, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1929, to Nov. 21, 19__ that I last saw her alive on Nov. 21, 1929, 19__ and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH* was as follows:

Paralysis Haemoplegia.
Third attack.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs.

(Signed) W. E. Patrick, M. D.

Nov. 22, 1929 (Address) Blackfoot Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Crove City Cemetery, Blackfoot, Idaho.

Date of Burial: Nov. 23, 19__

20. Undertaker: E. T. Pick

Address: Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68217

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2144

Local Registrar's No. 199

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lila Lauren Deakin

(a) Residence. No. Bt. Firth R F D 1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

84

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 8 1928

7. AGE: Years 1, Months 3, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Stone Idaho

PARENTS

10. NAME OF FATHER: J. R. Deakin
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Teton Basin Idaho
12. MAIDEN NAME OF MOTHER: Lala Sorensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Stone Idaho

14. Informant
(Address) Ralph Deakin

15. Filed Nov 26, 1929 Wm Walter E. Fabre Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 26 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Nov. 15, 1929
that I last saw her alive on Nov 15, 1929
and that death occurred, on the date stated above, at 5:45 A.m.
The CAUSE OF DEATH* was as follows: Abscess of Brain
(duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary) Otitis Media
(duration) ..... yrs. 2 mos. ..... ds.

18. Where was disease contracted if not at place of death? Kimball Idaho
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? History and symptoms
(Signed) W. R. Edgar D.O. M.D.
Nov 26, 1929 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Tree Mountain Utah — Date of Burial 19

20. Undertaker: E J Peck — Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68218

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194.

Local Registrar's No. 200

(No. Southern Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100 B

2. FULL NAME Andrew Peterson

(a) Residence. No. County Farm St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 6 Months mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Unknown — Years | Months | Days | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweeden

PARENTS

10. NAME OF FATHER: Ole Peterson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: No record

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweeden

14. Informant: Henry Gericke
(Address) Blackfoot

15. Filed Nov. 29, 1929 Mrs Charles E. Catine
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 27, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4, 1929, to Nov. 27, 1929

that I last saw him alive on Nov. 26, 1929

and that death occurred, on the date stated above, at 2:00 a.m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Geo. Williams, M. D.

Nov. 29th, 1929 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Asylum Cemetery — Date of Burial: Nov. 29 19

20. Undertaker: Louis Ely — Address: Blackfoot, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929

PLACE OF DEATH

County of Bingham

City of Blackfoot

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 1007

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 68219

Local Registrar's No. 201

2. FULL NAME Clayton Agustis Hoover

(a) Residence. No. Blackfoot, Idaho 490 Slout St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Bessie Brown Hoover

6. DATE OF BIRTH (month, day and year) Feb. 25, 1853

7. AGE: Years 76, Months 9, Days 5. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: M. D. and Surgeon

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10. NAME OF FATHER: Wm Hoover

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Washington D.C.

12. MAIDEN NAME OF MOTHER: Hough

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Va.

14. Informant: Moss G. Hoover
(Address) Blackfoot, Idaho

15. Filed: Nov. 30, 29. Mrs Walter E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1929, to Nov. 29, 1929

that I last saw him alive on Nov. 29, 1929

and that death occurred, on the date stated above, at 3. P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

..... (duration) ..... yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) F. A. Mitchell, M. D.

11/30, 1929 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Grove City Cemetery — Date of Burial: Dec 1st 1929

20. Undertaker: E. J. Peck — Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929

PLACE OF DEATH

County of Bingham

City of Blackfoot

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68220

Local Registrar's No. 202

2. FULL NAME Alfred Renberger

(a) Residence. No. Ringwood St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) November 3 1870

7. AGE Years 59 Months Days 27 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ruscott Kansas

PARENTS

10. NAME OF FATHER: Isaac Renberger

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Martha Adams

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Rabdolph Mo

14. Informant: Alfred L. Hahn

(Address) Ringwood

15. Filed Dec 2, 1929 Mrs Walter E. Catrine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Nov 30, 1929

that I last saw him alive on Nov 29, 1929

and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) J. O. Hampton M. D.

12-2 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Riverside Thomas — Date of Burial: Dec 3rd 1929

20. Undertaker: E. J. Peck — Address: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 10 1929

PLACE OF DEATH

County of Bingham

City of Moreland

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

DO NOT WRITE IN THIS SPACE

State File No. 68221

Local Registrar's No. 203

(No. 90)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Louisa Green

(a) Residence. No. Moreland, Ida St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Frank J. Green

6. DATE OF BIRTH (month, day and year): Jan 31, 1877

7. AGE — Years: 52 | Months: 9 | Days: 30 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Parowan Utah

PARENTS

10. NAME OF FATHER: John W. Brown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Cousens

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Frank J. Green

(Address): Moreland Idaho

15. Filed Dec 3, 1929 W. Lewis Ellis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 30 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30, 1929, to Nov 30, 1929

that I last saw her alive on She was dead when I arrived, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Sudden Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular heart trouble according to history

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? 12 yrs.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W W Beck, M. D.

12/2, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Moreland Cemetery — Date of Burial: Dec 3 1929

20. Undertaker: E J Tuck — Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 7 1929

PLACE OF DEATH

County of Bingham

City of Aberdeen

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 116

Primary Registration District No. 2195

DO NOT WRITE IN THIS SPACE

State File No. 68222

Local Registrar's No. 31

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Marie Giesbrecht

(a) Residence. No. Aberdeen, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Herman Giesbrecht

6. DATE OF BIRTH (month, day and year) May 1, 1863

7. AGE Years 66 Months 6 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Siewert Diahrt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Sarah Franz

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Herman Giesbrecht

(Address) Aberdeen Idaho

15. Filed 11/23, 1929 McMackinnon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14, 1929, to Nov 20, 1929

that I last saw h. 9 alive on Nov 20, 1929

and that death occurred, on the date stated above, at 5:30 p m.

The CAUSE OF DEATH* was as follows:

acute parenchymetous nephritis -

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no Laboratory

What test confirmed diagnosis?

(Signed) M. C. McKinnon, M. D.

11-23, 1929 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Homestead Cemetery Aberdeen Ida

Date of Burial 11-24 1929

20. Undertaker A W Davis American Falls Ida

Address

RECEIVED DEC 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68223

PLACE OF DEATH
County of Teton
City of Driggs R.F.D.1.

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Gotfred Durtschi.
(a) Residence. No. Driggs R.D.1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 1 1867.

7. AGE: Years 62, Months 3, Days ~~7~~ 7. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Hired man.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Spiez Switzerland

PARENTS
10. NAME OF FATHER: Gotfred Durtschi
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Spiez Switzerland.
12. MAIDEN NAME OF MOTHER: Anna Scharen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Spiez Switzerland.

14. Informant: John J. Durtschi
(Address) Driggs R.D.1. Idaho

15. Filed 11-14-, 1929. Martha Marker, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-8, 1929, to Nov 8, 1929
that I last saw him alive on Dead on arrival, 19
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart
(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary) Fallicular Tonsillitis
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. T. Parkinson, M. D.
11-9-, 1929 (Address) Driggs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pratt ward Cemetary. Date of Burial: Nov 10 1929

20. Undertaker: Lewis Kiser Address: Ashton Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68224

PLACE OF DEATH
County of Blaine
City of Bellevue

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 40

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard Broadhurst

(a) Residence. No. St. (Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	X

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 18th 1913

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	2	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gannett Idaho

PARENTS

10. NAME OF FATHER James Broadhurst
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Alice Sisiam
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Earl Hurst
(Address) Bellevue Idaho

15. Filed 12-10, 1929 W. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 3 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-3, 1929, to 11-3, 1929
that I last saw him alive on 11-3, 1929
and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Extreme spinal curviture

(duration) Birth mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Robert H. Wright, M. D.
11/4, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bellevue Idaho	Nov 5 1929
20. Undertaker	**Address**
Harris & Amos	Hailey.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68225

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 41

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas W. Walker Sr

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Walker

6. DATE OF BIRTH (month, day and year) Mar 25 - 1864

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Benton, Wis.

PARENTS

10. NAME OF FATHER Thomas Walker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant J. W. Walker Jr.
(Address) Hailey Idaho

15. Filed 12 - 10, 1929 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct - 28, 1929, to Nov - 8, 1929
that I last saw him alive on Oct - 28, 1929
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:
Broncho - Pneumonia
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Robert H. Wright, M. D.
11-9, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey Idaho	Nov 11 1929
20. Undertaker	Address
Harris & Amos	Hailey Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68226

PLACE OF DEATH

County of Blaine
City of Broadford

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 42

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Mc Cann

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Mc Cann

6. DATE OF BIRTH (month, day and year) Mar 25 1858

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	7	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mary McCann Johnson
(Address) Bellevue Ida

15. Filed 12-10, 1929 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8, 1929, to Nov 13, 1929
that I last saw h[illegible] alive on Nov 13, 1929
and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

..... (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E W [illegible], M. D.

11 14, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harris & Cimoz	Nov 15 1929
20. Undertaker	Address
Hailey Idaho	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68228

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 91

PLACE OF DEATH

County of Boise

City of Quartzburg (No.) 146

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arthur Edward Johnson

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Johnson

6. DATE OF BIRTH (month, day and year) Mar 17, 1897

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32	8	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer) Mining

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Manchester Mass.

PARENTS

10. NAME OF FATHER Edward Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland

12. MAIDEN NAME OF MOTHER Ellen Erickson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant Edward Johnson

(Address) Mountain Home Idaho.

15. Filed 11-27, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mining Accident.
Killed instantly

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) S

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) H. A. Schlosser, M. D.

, 19 (Address) Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain Home Idaho — Date of Burial: Nov 24 29

20. Undertaker: Summers & Krebs — Address: Boise Idaho

RECEIVED DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68229

PLACE OF DEATH

County of Bonner

City of Priest River

Registration District No. 85

Primary Registration District No. 2185

Local Registrar's No. 33

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Gray

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

146

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	45			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lumerman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Humbird Lumber Company

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Humbird Lumber Co.

(Address) Sandpoint, Idaho

15. Filed Nov. 26, 1929 R. E. Weeks Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 18, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Accidental explosion of Dynamite

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) L. H. Moon - Coroner

Nov. 20th, 1929 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I. O. O. F. Cemetery	Nov. 27, 1929

20. Undertaker — Address

Moon Mortuary, Priest River, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68230

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonner
City of Priest River

Registration District No. 85
Primary Registration District No. 2185
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 32

2. FULL NAME Raymond Alfred Seymour

101 B

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 2, 1929

7 AGE Years: Months 6 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Priest River, Idaho

PARENTS
10 NAME OF FATHER A. L. Seymour
11 BIRTHPLACE OF FATHER (city or town) (State or country) Spooner Wis.
12 MAIDEN NAME OF MOTHER Lucille Gravell
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Akeley, Minn.

14 Informant A. L. Seymour
(Address) Priest River Ida.

15 Filed Nov. 8, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November (Month) 7, (Day) 1929 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from October 2, 1929, to November 7, 1929, that I last saw him alive on November 6, 1929, and that death occurred, on the date stated above, at 2:30 A.m.

The CAUSE OF DEATH* was as follows: Pneumonia - Left side (Second flare up)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia 4 wks before Marasmic (duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical signs

(Signed) E. L. Spohn, M. D.
Nov 7th 1929 (Address) Priest River Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Woodmen Cemetery
Date of Burial: Nov. 8 1929

20. Undertaker: Moon Mortuary
Address: Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6823

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 7F

Primary Registration District No. 2155

(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME Mary Sofia Nelson

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. 23 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Magnus Nelson

6. DATE OF BIRTH (month, day and year): Sept. 1, 1866

7. AGE — Years: 63 | Months: 2 | Days: 28 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Grassmarka Sweden

PARENTS

10. NAME OF FATHER: Ole Olson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Christine Pierson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Mrs. Myrtle Powell

(Address): Sandpoint, Idaho

15. Filed Nov 30, 1929 Floyd G. Wendle, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 29, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23, 1929, to Nov 29, 1929, that I last saw her alive on Nov. 29, 1929, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease Enlarged thyroid.

(duration) years yrs. mos. ds.

CONTRIBUTORY (Secondary): influenza pneumonia

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Floyd G. Wendle, M. D.

Nov 30, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	12/1/29

20. Undertaker	Address
Moon Mortuary	Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68232

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.

(No. 153
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Cayouette
(a) Residence. No. Wisconsin Hotel St. Newport, Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years 65 Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer H. L. Company, Caribou

9. BIRTHPLACE (city or town) (State or country) Maine.

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. J. A. Adams.
(Address) Sandpoint, Ida.

15. Filed Nov 22, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Pulmonary abscess
Not tubercular

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Floyd A. Wendle, M. D.
Nov. 22, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pinecrest Cemetery
Date of Burial Nov. 22, 1929

20. Undertaker Moon Mortuary
Address Sandpoint Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

PLACE OF DEATH

County of Bonner

City of Dufort

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68233

Registration District No. 78

Primary Registration District No. 2155.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Michael McConnell. 183

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth McConnell

6. DATE OF BIRTH (month, day and year) Apr. 24, 1875

7. AGE Years 54 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER Michael McConnell.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Ann Cooper

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa.

14. Informant Charles McConnell
(Address) Colburn, Idaho

15. Filed Nov. 5, 1929 Viola Alley Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 3, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 2:15 p.m.

The CAUSE OF DEATH* was as follows:

Accidental Gunshot Wound.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. Moon Coroner, M. D.

Nov. 5, 1929 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pinecrest Cemetery

Date of Burial Nov. 5, 1929

20. Undertaker Moon Mortuary

Address Sandpoint, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68234

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

(No. 331 S. Florence Ave)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

161a

2. FULL NAME Arthur James Zinter

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 29, 1929

7. AGE Years Months 1 Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sandpoint Idaho

PARENTS

10. NAME OF FATHER William Zinter

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Alexander Minn

12. MAIDEN NAME OF MOTHER Emma Bertsen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant William Zinter

(Address) Sandpoint, Idaho

15. Filed Nov. 2, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 31, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29th, 1929, to October 31, 1929 that I last saw him alive on October 24, 1929 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth. (during 8th month of pregnancy)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) F. B. Evans, M. D.

Nov. 2, 1929 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pinecrest Cemetery

Date of Burial Nov. 2 1929

20. Undertaker MOON MORTUARY

Address Sandpoint, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68936

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louis Peter Colomb. 90
(a) Residence. No. 920 Main St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 61 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Married
5a. If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~: Delima Colomb.
6. DATE OF BIRTH (month, day and year): Dec. 20, 1851
7. AGE: Years 77 | Months 11 | Days 3 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Woodsman.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Port Leve Canada.

PARENTS
10. NAME OF FATHER: Peter Colomb.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Port Leve Canada.
12. MAIDEN NAME OF MOTHER: Lucy Gay
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Port Leve Canada.

14. Informant: W. R. Colomb
(Address): Sandpoint, Idaho.
15. Filed Nov. 25, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF ~~DEATH~~: Nov. 23, 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to Nov. 23, 1929, that I last saw h~~im~~ alive on Nov 15, 1929, and that death occurred, on the date stated above, at 7:00 A. m.
The CAUSE OF DEATH* was as follows:
Arteria Sclerosis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) 2 yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Wm F Lyder, M. D.
Nov. 23, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pinecrest Cemetery — Date of Burial: Nov. 25, 1929
20. Undertaker: Moon Mortuary — Address: Sandpoint, Ida.

REC'D DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68237

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.

PLACE OF DEATH

County of Bonner
City of Dover
(No.) 164
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carrie Nystrom

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of A. P. Nystrom

6. DATE OF BIRTH (month, day and year) Feb. 21,

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	9	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Andrew Flodvig
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs. J. Arneson
(Address) Dover, Idaho

15. Filed Nov. 26, 1929 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF ~~DEATH~~ Nov. 25, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 19th 1929, to November 25, 1929
that I last saw h-er alive on November 19, 1929
and that death occurred, on the date stated above, at 7:30 A m.
The CAUSE OF DEATH* was as follows:
Infirmities of old age (No definite disease)
(duration) Bedfast yrs. mos. 10 ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. D. Graves M. D.
11-26, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Nov. 27 1929
20. Undertaker	Address
Moon Mortuary	Sandpoint Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68238

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2100
Local Registrar's No. 2

(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

179

2. FULL NAME Donna Campbell

(a) Residence. No. Iona, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 23, 1927

7. AGE: Years 3 | Months 6 | Days 1 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER James Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lorenzo, Idaho
12. MAIDEN NAME OF MOTHER Lydia Frandsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iona, Idaho

14. Informant Mrs James Campbell
(Address) Iona, Idaho

15. Filed Oct 26, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~October~~ October 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5th, 1929, to Oct 24, 1929
that I last saw h[illegible] alive on Oct 24, 1929
and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:
Burns Accidental, getting too close to a Bonfire [illegible]
(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~
Did an operation precede death? no Date of ~
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) A. P. Dahlquist, M. D.
10/28, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Iona, Idaho	Oct 27 1929

20. Undertaker Jack A. Wood — Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68239

Registration District No. 73

Primary Registration District No. 21 V-8

Local Registrar's No. 201

(No. ~~[illegible]~~)

(If death occurred in a hospital or institution, give its name instead of street and number.)

88B

2. FULL NAME Harry Blumkin

(a) Residence. No. 302 - Napton, Apts St. Butte Montana

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 16, 1872

7. AGE Years 59 Months 5 Days 11 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Capitalist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10. NAME OF FATHER Elias Blumkin

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant Mrs Harry Blumkin

(Address) Butte Mont

15. Filed Oct 28, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 27 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1929 to Oct. 27, 1929

that I last saw him alive on Dead when I saw him first

and that death occurred, on the date stated above, at 9-30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Marquette

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John O. Mellor, M. D.

Oct 27, 1929 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Butte Montana

Date of Burial Oct 31 1924

20. Undertaker Jack A. Wood

Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED NOV 18 1929

DO NOT WRITE IN THIS SPACE
State File No. 68240

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 202
(No. 509 Lomax Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Loren Paul Mead.
(a) Residence. No. Idaho Falls Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 0 | Months 0 | Days 2. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Ida

PARENTS
10. NAME OF FATHER: Jack Mead.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Greeley Colo.
12. MAIDEN NAME OF MOTHER: May Walker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Lewisville Idaho.

14. Informant: Jack Mead.
(Address) Idaho Falls Ida.

15. Filed Nov 2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30, 1928, to 31 Oct, 1928
that I last saw him alive on 31 Oct 1928
and that death occurred, on the date stated above, at 3 30 A m.
The CAUSE OF DEATH* was as follows: Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. F. Kettering D.C., ~~M. D.~~
, 19 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: Nov 2 1929

20. Undertaker: V. F. McHan. | Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68241

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21 V-0

Local Registrar's No. 203

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME William Junior Wise

(a) Residence. No. 351 Lava St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 3, 1929

7. AGE: Years | Months: 5 | Days: 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER: Levi William Wise
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Shelton, Idaho
12. MAIDEN NAME OF MOTHER: Edatta B Cain
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Lewiston, Utah

14. Informant: John Wise
(Address) 1 Eastern Ave Idaho Falls

15. Filed Nov 18, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26, 1929, to Nov 1, 1929
that I last saw him alive on Nov 1, 1929
and that death occurred, on the date stated above, at 5 7 m.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) A. W. Cain M.D.
Nov 2, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Rose Hill	Nov. 3 1929
20. Undertaker	Address
Jack A. Hood	Idaho Falls

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68242

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 214
Local Registrar's No. 204

(No. 30-B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Egan

(a) Residence. No. 257 Cliff St. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Scotland
(State or country)

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) Scotland
(State or Country)
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) Scotland
(State or Country)

14. Informant M. Frank Johnson
(Address) Idaho Falls Idaho

15. Filed Nov 2, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 31, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 4-45a m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Myocarditis
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Wm Fennaud M D, M. D.
....., 19..... (Address) Ida. Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho	Nov 2 1929
20. Undertaker	Address
Jack A. Ward	Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 24 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Wm. Kinnaird
Idaho Falls, Ida.

68242

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

E. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:
Thomas Egan who died at Idaho Falls, Idaho on Oct. 31, 1929

Information DESIRED in order to complete certificate.

PLEASE STATE THE CAUSE OF DEATH.

PLEASE ANSWER BELOW

Thomas Egan - Place of death - Idaho Falls, Idaho.
Date - - October 31, 1929.

Cause of death - Chronic nephritis-
Myocarditis.

W. Finnis M.D.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68243

PLACE OF DEATH

County of Bonneville. Registration District No. 3

City of Idaho Falls. Primary Registration District No. 1210

Local Registrar's No. 20 N

(No. L. D. S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dale Christensen. 90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 29-28

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	4	3	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls. Ida.

PARENTS

10. NAME OF FATHER Albert M. Christensen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hyde Park. Utah

12. MAIDEN NAME OF MOTHER Idella. Webster.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Grant. Idaho

14. Informant A. M. Christensen.
(Address) Roberts Idaho.

15. Filed Nov 2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 2. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929, to Nov 2, 1929
that I last saw h alive on Nov 2, 1929
and that death occurred, on the date stated above, at 1030 P. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 6 hrs

18. Where was disease contracted if not at place of death? Roberts

Did an operation precede death? No Date of

What test confirmed diagnosis? Laboratory Tests

(Signed) [signature], M. D.

11/2, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grant. Idaho.	Nov. 3 1929

20. Undertaker W. F. McHan. Idaho Falls, Ida.
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68244

PLACE OF DEATH
County of Bingham
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. L.D.S.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 206

100a

2. FULL NAME Allen J Cook
(a) Residence. No. Taylor Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 5 - 1929

7. AGE Years | Months 5 | Days 10 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Tea.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Ida

PARENTS
10. NAME OF FATHER: Lester J Cook.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah.
12. MAIDEN NAME OF MOTHER: Alice Priest
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho.

14. Informant: Lester J Cook.
(Address) Taylor Ida

15. Filed Oct 24, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1929, to Oct 20, 1929
that I last saw him alive on Oct 20, 1929
and that death occurred, on the date stated above, at 10 9 m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? Shelley, Ida
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
..., 19... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Taylor Cem. | Date of Burial: Oct 24 1929

20. Undertaker: Cliff C Hazen | Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68246

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 3

Primary Registration District No. 2150

Local Registrar's No. 2

(No. L-D S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ray C. Wilhight

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Ray C. Wilhight

6. DATE OF BIRTH (month, day and year): Oct 6 - 1903.

7. AGE: Years 26, Months 1, Days 3. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Linotype operator

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: The Idaho Falls Post

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Ida.

PARENTS

10. NAME OF FATHER: George D Wilhight

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Lillie Foster

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Texas

14. Informant: Mrs. R C Wilhight

(Address): Idaho Falls Ida

15. Filed Nov 12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to Nov 9, 1929

that I last saw him alive on Nov 8, 1929

and that death occurred, on the date stated above, at 11:15 A.m.

The CAUSE OF DEATH* was as follows:

Abscess Lung

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes No Date of May 7 -

Was there an autopsy? X ray

What test confirmed diagnosis?

(Signed) [signature], M. D.

....., 19..... (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls. Ida. Date of Burial: Nov 13 1929

20. Undertaker: V. F. McHan. Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68247

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 13
Primary Registration District No. 2150
Local Registrar's No. 29
(No. C. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Betty Lou Dearden
(a) Residence. No. ..... St. 24
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Jan 26-1928

7. AGE: Years 1, Months 9, Days 14; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Woodville Idaho

PARENTS

10. NAME OF FATHER: Wm Earl Dearden Jr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Woodville Ida.
12. MAIDEN NAME OF MOTHER: Thelma Gifford
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Woodville Ida.

14. Informant: Wm Earl Dearden Jr.
(Address): Woodville Idaho

15. Filed Nov 13, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 10 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1929, to Nov 10, 1929
that I last saw her alive on Nov 10, 1929
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral Spinal Meningitis
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Pneumonia Bronchial
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? Shelley
Did an operation precede death? Yes Date of Spinal puncture 18/10/29
Was there an autopsy? No
What test confirmed diagnosis? Spinal fluid exam
(Signed) [signature], M. D.
11/10, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: Nov 11 1929.

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68248

Registration District No. 73

Primary Registration District No. 21N-0

Local Registrar's No. 210-

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ann Sarah Odell Wright

(a) Residence. No. 510 No Capital Ave St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 32 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced, (write the word): Widowed

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Gilbert J. Wright

6. DATE OF BIRTH (month, day and year) March 27 1847

7. AGE: Years 82, Months 7, Days 4. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): London England

PARENTS

10. NAME OF FATHER: Thomas George Odell

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Newman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Eugene Wright
(Address) Idaho Falls, Idaho

15. Filed Nov 2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Nov 1, 1929

that I last saw her alive on Oct 31, 1929

and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) [signature], M. D.

....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Rose Hill — Date of Burial: Nov. 3 1929

20. Undertaker: Jack A. Wood — Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68249

PLACE OF DEATH
County of Bonneville
City of Popular

Registration District No. 73
Primary Registration District No. 2150
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 211

2. FULL NAME David Blair Rice

(a) Residence. No. Popular Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Alice Rice

6. DATE OF BIRTH (month, day and year) June 30 1864

7. AGE Years 65 Months 4 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden, Utah

PARENTS

10. NAME OF FATHER James Rice
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Murell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Alice Rice
(Address) Popular, Idaho.

15. Filed Nov 13, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1929, to Oct 5, 1929
that I last saw him alive on Oct 5, 19..
and that death occurred, on the date stated above, at 11:30 A.m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Cervical Glands neck
..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? Yes Date of 1928
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) [signature], M. D.
11/9, 1929 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rose Hill
Date of Burial Nov. 12 1929

20. Undertaker Jack A. Wood
Address Idaho Falls

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6825

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2120
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 212

2. FULL NAME Grace Edna Dodge

(a) Residence. No. 257 Hill St. 1000
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 11, 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
		1	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls (State or country) Idaho.

PARENTS

10. NAME OF FATHER Marvin Dodge
11. BIRTHPLACE OF FATHER (city or town) Stevensville (State or Country) Montana
12. MAIDEN NAME OF MOTHER Ann Eldridge
13. BIRTHPLACE OF MOTHER (city or town) Missoula (State or Country) Montana

14. Informant Mrs Marvin Dodge
(Address) 257 Hill St.

15. Filed Nov 13, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4, 1929, to Nov. 13, 1929, that I last saw her alive on Nov 12, 1929, and that death occurred, on the date stated above, at 9:30A m.

The CAUSE OF DEATH* was as follows:
Bronchial pneumonia
(duration) yrs. mos. 15 ds.
CONTRIBUTORY (Secondary) Inanition
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [signature] M. D.
11/13/29 19 (Address) Idaho Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rose Hill	Nov. 14 1929
20. Undertaker	Address
Jack A. Wood	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68251

Registration District No. 73

Primary Registration District No. 2170

Local Registrar's No. 213

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

118B

2. FULL NAME Mary Porter

(a) Residence. No. R. F. D. #4, Blackfoot, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: R. E. Porter

6. DATE OF BIRTH (month, day and year): June 11, 1888

7. AGE: Years 41, Months 5, Days 2. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Lakeshore, Utah.

PARENTS

10. NAME OF FATHER: Larenzo Argyle

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Burmingham, England.

12. MAIDEN NAME OF MOTHER: Emily Manwell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Payson, Utah.

14. Informant: R. E. Porter
(Address): Blackfoot R.D. #4

15. Filed Nov 14, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month), 14 (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8, 1929, to Nov 14, 1929 that I last saw her alive on Nov 13, 1929 and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows: Acute intestinal obstruction with gangrene (duration) ___ yrs. ___ mos. 6 ds.

CONTRIBUTORY (Secondary) ___ (duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of Nov 13-

Was there an autopsy? no

What test confirmed diagnosis? physical finding

(Signed) J. O. [signature], M.D.

11-14, 1929 (Address) Blackfoot Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery

Date of Burial: Nov. 16, 19

20. Undertaker: E.T.Peck, Blackfoot, Idaho.

Address

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68252

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 210-0
(No. LDS Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 149

2. FULL NAME Veda Lula Sellers.

(a) Residence. No. 154-16th St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

88a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 9-1914

7. AGE Years 14 Months 9 Days - If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls

PARENTS
10. NAME OF FATHER Chas Sellers.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.
12. MAIDEN NAME OF MOTHER Lula Hines
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Mrs Lula Brandt
(Address) Idaho Falls

15. Filed Oct 10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1929, to Oct. 10, 1929, that I last saw her alive on Oct. 9, 1929, and that death occurred, on the date stated above, at 2:50 A. m.

The CAUSE OF DEATH* was as follows:
Ulcerative Endo Carditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism + Other Medi (duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Symp
(Signed) [signature] Sutton, M. D.
10-10-29, 19 (Address) Ida Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Iona Ida. Date of Burial Oct 13 1929

20. Undertaker Cliff Hayes Address Idaho Falls

Dr. Sutton.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68253

Registration District No. 3
Primary Registration District No. 21-0
Local Registrar's No. 1 5 0

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. Spencer Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arthur Gillespie

(a) Residence. No. Ashton, Idaho St. 1110

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 26, 1903

7. AGE — Years: 26 | Months: 6 | Days: 14 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Arbor Vida. Wisconsin

PARENTS

10. NAME OF FATHER: John Gillespie
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wisconsin
12. MAIDEN NAME OF MOTHER: Elizabeth Costello
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wisconsin

14. Informant: Goodie E. Gogue
(Address) Ashton, Idaho

15. Filed Oct. 14, 1929 C. Freeman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9, 1929, to Oct 10, 1929
that I last saw him alive on Oct 10, 1929
and that death occurred, on the date stated above, at 6-15 p m.

The CAUSE OF DEATH* was as follows:
Ulcer of the stomach at Pylorus & chronic appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Oct 10-29
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) C. Freeman M. D.
Oct 14, 1929 (Address) Ida Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashton, Idaho — Date of Burial: Oct 14 1929

20. Undertaker: Jack A. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68254

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2170
Local Registrar's No. 191
(No. U. S. Hospital 486)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William B. Thomas

(a) Residence. No. ... St. Jackson, Wyoming
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Fay Thomas
6. DATE OF BIRTH (month, day and year)
7. AGE: Years: 21 | Months | Days | If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Elwood Indiana

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Bruno Jemon
(Address) Jackson Wyoming
15. Filed Oct 16 - 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 14 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1929 to Oct. 14, 1929
that I last saw h[illegible] alive on Oct. 14, 1929
and that death occurred, on the date stated above, at 10 50 a.m.
The CAUSE OF DEATH* was as follows: Endocarditis (chronic)
Mitral and aortic insufficiency
Pericarditis with effusion
2 weeks (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Malignile
(duration) ... yrs. ... mos. ... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John O. Millar, M. D.
Oct 16, 1929. (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jackson, Wyoming — Date of Burial: Oct. 17 1929
20. Undertaker: Jack A. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68255

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21N-0
(No. U. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 192

65a

2. FULL NAME Henry Schneider
(a) Residence. No. Idaho Falls, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) August 8, 1912

7. AGE: Years 17, Months 2, Days 6. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Chicago, Illinois

PARENTS

10. NAME OF FATHER: Oase Schneider
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Henrietta Doutz
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Oase Schneider
(Address) Idaho Falls, Idaho

15. Filed Oct 16, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12, 1929, to Oct 14, 1929 that I last saw him alive on Oct 14, 1929 and that death occurred, on the date stated above, at 6-45 p m.

The CAUSE OF DEATH was as follows: Lymphoid Leukemia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) R J Sutton M. D.
10-16, 1929. (Address) Idaho Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho
Date of Burial: Oct 16 1929

20. Undertaker: Jack C. Wood
Address: Idaho Falls

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68256

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21 V-0
Local Registrar's No. 193

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Straight Lee 4480

(a) Residence. No. 340 Maple Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Frank A. Lee

6. DATE OF BIRTH (month, day and year) June 28, 1874

7. AGE Years 55 Months 3 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House-wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Oregon City
(State or country) Oregon

PARENTS
10. NAME OF FATHER Straight
11. BIRTHPLACE OF FATHER (city or town) New York
(State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) Iowa
(State or Country)

14. Informant Miss Marguerite Gratz
(Address) 360 Maple Ave. Idaho Falls Ida.

15. Filed Oct 17, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1929, to Oct 14, 1929
that I last saw her alive on dead, 19..
and that death occurred, on the date stated above, at 1:30 a.m.
The CAUSE OF DEATH* was as follows: Chronic Myocarditis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) yrs. mos. 10 min.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptom History
(Signed) H D Fletcher, M. D.
Oct 16, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Rose-Hill — Date of Burial Oct. 17 1929

20. Undertaker Jack A. Wood — Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68257

Registration District No. 73

Primary Registration District No. 2140

Local Registrar's No. 194

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Annie Sarah Jane Gordon

(a) Residence. No. Ucon, Idaho St. Ucon Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Robert Gordon

6. DATE OF BIRTH (month, day and year) September 12, 1894

7. AGE Years 35 Months 1 Days 6 If LESS than 1 day ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ucon, Idaho

PARENTS

10. NAME OF FATHER Joseph Ray

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Louisiana

12. MAIDEN NAME OF MOTHER Lizzie M. Peterson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bearlake Idaho.

14. Informant Mrs Lizzie M. Ray

(Address) Ucon Idaho

15. Filed Oct 19, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5, 1929, to Oct 18, 1929

that I last saw her alive on Oct 18, 1929

and that death occurred, on the date stated above, at 8:35 A m.

The CAUSE OF DEATH* was as follows: Acute Myocarditis result of Meningitis.

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Meningitis, Epidemic Spinal (duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? Ucon Idaho

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab.

(Signed) W. P. West, M. D.

10/21, 1929. (Address) Rigby, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation or Removal~~ Ucon Idaho — Date of Burial Oct. 20 1929

20. Undertaker Jack A. Wood — Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68258

PLACE OF DEATH

County of Bonneville.
City of Idaho Falls.

Registration District No. 73
Primary Registration District No. 21 1-0
(No. C-D. S Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 196

162

2. FULL NAME Thelma Jayce Schuldt.

(a) Residence. No. R R 6 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) August 13-1929.

7. AGE: Years 0, Months 1, Days 29. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls. Ida.

PARENTS

10. NAME OF FATHER Ernest Schuldt.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cushing Iowa
12. MAIDEN NAME OF MOTHER Thelma Belnap.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arco Idaho.

14. Informant Ernest Schuldt.
(Address) Idaho Falls Ida.

15. Filed Oct 22, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 13. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1929, to Oct. 13, 1929
that I last saw her alive on Oct. 13, 1929.
and that death occurred, on the date stated above, at 9.15 P. m.
The CAUSE OF DEATH* was as follows:
Hemophilia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Lab.
(Signed) W. R. West, M. D.
Oct. 14, 1929 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: Oct 15 29

20. Undertaker: V. F. McHan. Address: Idaho Falls, Ida.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68259

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21-0
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 197

2. FULL NAME Christianner R Rhoades

(a) Residence. No. 335 - H. St. Idaho Falls
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

24

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: LeRoy Rhoades

6. DATE OF BIRTH (month, day and year): March 20, 1869

7. AGE: Years 60 | Months | Days 2 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Meadow Utah

PARENTS
10. NAME OF FATHER: John Shelton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: LeRoy Rhoades
(Address): Idaho Falls, Idaho

15. Filed Oct 24, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18, 1929, to Oct 22, 1929
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:

Epidemic Cerbro Spinal Meningitis
(duration) ____ yrs ____ mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? Laboratory
What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.
Oct 24, 1929 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Setonia, Idaho	Oct 24 1929
20. Undertaker: Jack A. Wood	Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68260

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 191

2. FULL NAME James Ephriam Steele
(a) Residence No. 408 H. St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

100a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elvira C. Steele

6. DATE OF BIRTH (month, day and year) June 22 1852

7. AGE Years 77 Months 3 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Manchester England

PARENTS
10. NAME OF FATHER James Steele
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Elizabeth Wyley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant H. Steele
(Address) Ellis Apts, Idaho Falls, Idaho

15. Filed Oct 25, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 18, 1929, to Oct. 18, 1929
that I last saw h..... alive on Oct. 18, 1929
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia
..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Chronic myocarditis and chronic sudoc. ..... (duration) ..... yrs. ..... mos. ..... ds.
nephritis

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John O. Mellar, M. D.
Oct. 22, 1929 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Rose Hill — Date of Burial Oct. 22 1929

20. Undertaker Jack A. Wood — Address Idaho Falls

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68261

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21 V-0
(No. Spencer Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 199

90

2. FULL NAME Chas J Peterson
(a) Residence. No. Ashton Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: about 70. Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): —

PARENTS
10. NAME OF FATHER: Don't know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant
(Address)

15. Filed Oct 25, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13, 1929, to Oct 19, 1929
that I last saw him alive on Oct 19, 1929
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? —
What test confirmed diagnosis?
(Signed) H D Spencer, M. D.
Oct 22, 1929 (Address) Ida Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashton Idaho | Date of Burial: Oct 26 1929

20. Undertaker: Cliffe Hazie | Address: Idaho Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68263

Registration District No. 73

Primary Registration District No. 2 1 V-0

Local Registrar's No. 184

(No. 2 W 8)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry C Smith

(a) Residence. No. ..... St. ..... (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Dec 5

7. AGE: Years 49 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Vermont

PARENTS

10. NAME OF FATHER: Gordon Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country): New Hampshire

12. MAIDEN NAME OF MOTHER: Mary J Lyon

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Vermont

14. Informant: Frieda Smith

(Address): Kilgore Ida

15. Filed Oct 9, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1929, to Oct 4, 1929

that I last saw him alive on Oct 3, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

..... (duration) ..... yrs. ..... mos. 30 ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Spencer, Ida

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) [signature], M. D.

....., 19..... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spencer Ida | Date of Burial: Oct 6 1929

20. Undertaker: Cliff Hayes | Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68263

Registration District No. 73

Primary Registration District No. 21 V-0

Local Registrar's No. 145

(No. L D S Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

143a

2. FULL NAME Lila Small

(a) Residence. No. Small Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 13 - 1896

7. AGE 33. Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS

10. NAME OF FATHER A D Miller

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Neb.

12. MAIDEN NAME OF MOTHER Minnie Postlewait

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Neb.

14. Informant Hugh Small

(Address) Small Ida

15. Filed Oct. 9, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929, to Sept 24, 1929

that I last saw her alive on Sept. 24, 1929

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

Septic Abortion

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Small Idaho

Did an operation precede death? yes Date of Sept 15-29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. R. Sodenquist M. D.

Oct. 9, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Small Idaho. | Date of Burial Sept 1929

20. Undertaker Cliff Hayes | Address Idaho Falls

Dr Sodenquist.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68264

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 186
(No. L.D.S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George A Date.
(a) Residence. No. Ucon Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

114

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: Japanese
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 2-1927

7. AGE: Years 2, Months 7, Days 0. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ucon Ida.

PARENTS

10. NAME OF FATHER: Joe Date.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Japan.
12. MAIDEN NAME OF MOTHER: Haruko Harada.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ammon Ida

14. Informant: Mrs Joe Date.
(Address) Idaho Falls Ida

15. Filed Oct 10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1929, to Oct. 9, 1929, that I last saw him alive on Oct. 9, 1929 and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis with Convulsions

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

(Signed) Harry L. Willson, M. D.

Oct 10, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls. Date of Burial 19

20. Undertaker: V. F. McHan Address Idaho Falls Ida.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68265

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2150

Local Registrar's No. 147

(No. Le D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thelma Keller

(a) Residence. No. R. D. 2 - ~~[illegible]~~ St. 24
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 9 - 1912

7. AGE: Years 17, Months 3, Days 1. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mink Creek. Idaho.

PARENTS

10. NAME OF FATHER: Sylvester A. Keller

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Box Elder Co. Utah.

12. MAIDEN NAME OF MOTHER: Hanna Larsen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mink Creek. Ida

14. Informant: Sylvester A. Keller
(Address): R. D. 2. Rigby Ida.

15. Filed Oct 10, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8, 1929, to Oct 16, 1929
that I last saw her alive on Oct 9, 1929
and that death occurred, on the date stated above, at 4:55 A. m.
The CAUSE OF DEATH* was as follows:
Epidemic Cerebro
Spinal Meningitis
(duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary): Rheumatic endocarditis
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No Rinc
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) [signature], M. D.
....., 19..... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Milo Cemetery. Date of Burial: Oct 12 1929

20. Undertaker: V. F. McHan Idaho Fal Ida. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68366

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2107
Local Registrar's No. 1
(No. I. F. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Percival Lloyd Jones

(a) Residence. No. Ucon, Idaho St. Ucon, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 16, 1914

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
15	3	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rexburg, Idaho

PARENTS

10. NAME OF FATHER Percy D. Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Nola Fogelsong
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Mrs P. J. Jones
(Address) Ucon, Idaho.

15. Filed Oct 10, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not see him alive, 19
that I last saw him alive on , 19
and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebro Spinal Meningitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ucon, Idaho
Did an operation precede death? No Date of
Was there an autopsy? No Laboratory
What test confirmed diagnosis?
(Signed) [signature], M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Ucon	Oct. 10 1929

20. Undertaker	Address
Jack A. Ward	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68267

PLACE OF DEATH

County of Camas
City of Fairfield

CERTIFICATE OF DEATH

Registration District No. 58
Primary Registration District No. 2138
(No.) Local Registrar's No. 1
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME John R. Hedenberg

(a) Residence No. St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec 24, 1881

7 AGE: Years 47 Months 10 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10 NAME OF FATHER Albert Hedenberg
11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden
12 MAIDEN NAME OF MOTHER Olivia Pearson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Sven R. Hedenberg
(Address) Walnut Grove Minn

15 Filed Nov 1, 1929 Minnie Perkins Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 31 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1929, to Oct. 31, 1929, that I last saw him alive on Oct. 31, 1929, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Cardio Renal Insufficiency
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? symptoms
(Signed) A. O. Sheets, M. D.
10/31, 1929 (Address) Fairfield Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Tracy Minnesota
Date of Burial: Nov 2 1929

20. Undertaker: H. L. McHan
Address: Pocatello Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68268

PLACE OF DEATH

County of Camas
City of Fairfield

CERTIFICATE OF DEATH

Registration District No. 58
Primary Registration District No. 2138
(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Lee Nelson Lamson

(a) Residence. No. Fairfield St. Idaho

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 30, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	9+0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fairfield, Idaho

PARENTS

10 NAME OF FATHER E. Leland Lamson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alma Neb.

12 MAIDEN NAME OF MOTHER Hattie Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Harry J. Lamson
(Address) Fairfield Idaho

15 Filed Jul 15, 1929 Minnie Perkins Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 1 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 1, 1929, that I last saw alive on May 1, 1929, and that death occurred, on the date stated above, at 8-30 P. m.

The CAUSE OF DEATH* was as follows:

Automobile accident

(duration) instantly killed yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. L. Sheets, M. D.

, 19 (Address) Fairfield Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Mt. View Cemetery Fairfield, Idaho	May 3 1929
20. Undertaker E. J. McHan	Address Fairfield Idah

WRITE PLAINLY, WITH UNFA
N. B.—Every item of information should be carefully suppli
should state CAUSE OF DEATH in plain terms, so that it may
CUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68269

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 133

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

126

2. FULL NAME Carl A. Gahley
(a) Residence. No. Parma #2 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 5

7. AGE Years 37 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Harlan Co. Nebraska

PARENTS

10. NAME OF FATHER John A Gahley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mary E Englehorn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Martin Gahley
(Address) Parma Idaho

15. Filed 12-8-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28, 1929, to Dec 5, 1929
that I last saw him alive on Dec 5, 19..
and that death occurred, on the date stated above, at 11-30 P. m.
The CAUSE OF DEATH* was as follows:
Pneumonitis (Ruptured appendix)
peritonitis (duration) ..... yrs. ..... mos. 8 ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec Nov 28
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. McCoy M. D.
12/6, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Tucker Cem. Date of Burial: Dec. 8 1929

20. Undertaker: L. V. Peckham Address: Caldwell Idaho

Kaley RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68270

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 132

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James G. Gartin 49

(a) Residence. No. 1108 Cleveland St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Ella Gartin

6. DATE OF BIRTH (month, day and year) Jan 1 - 1860

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	11	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant William W. Gartin
(Address) Mt. Home.

15. Filed 12-8-, 1929 John S. Meyes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29, 1929, to Dec 5, 1929
that I last saw him alive on Dec 5, 1929
and that death occurred, on the date stated above, at 9-30 a m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) [signature], M. D.
12-6-, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: Dec. 8 1929

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Kaley

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6827

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005

Local Registrar's No. 131

(No. 1013)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mack Campbell

(a) Residence. No. South Indiana + Linden St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	married -

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July - 28 - 1869

7. AGE	Years	Months	Days	If LESS than 1 day,
	60	4	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Duncan Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Mary McCall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs Mack Campbell
(Address) Caldwell - Idaho.

15. Filed 12-4-, 1929 John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec - 1 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1929, to Dec 1-, 1929
that I last saw him alive on Nov 30, 1929
and that death occurred, on the date stated above, at 3:00 a.m.
The CAUSE OF DEATH* was as follows:
Pneumonia

(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Paralysis Agitans
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam

(Signed) C. M. Kaley, M. D.
12-2-, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Dec. 4- 1929
20. Undertaker	Address
C. V. Packham	Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Cole

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68272

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

Local Registrar's No. 130

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME James Henry Ayers

(a) Residence. No. 507 Grant St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND ~~of~~ (or) ~~WIFE of~~ Carrie Ayers

6. DATE OF BIRTH (month, day and year) Mar. 28 - 1848

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
81	8	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Richmond Vir

PARENTS

10. NAME OF FATHER Peter Ayers

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vir

12. MAIDEN NAME OF MOTHER Frances A. Tanner

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant Mrs. Leland M. Hannah
(Address)

15. Filed 11-30-, 1929- John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov- (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29, 1929, to Nov 29, 1929

that I last saw him alive on Nov 29, 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Carcinoma of stomach

..... (duration) ..... yrs. seven mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J M Cole, M. D.

11/30, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill

Date of Burial: Dec-1- 1929

20. Undertaker: C. V. Beckham

Address: Caldwell

Rec 7967

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Whittenberger

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68273

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

Local Registrar's No. 129

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Mary Jane Reeves

(a) Residence. No. 1314 Cleve St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of Edward S. Reeves

6. DATE OF BIRTH (month, day and year) May-1-1854

7. AGE: 7 Years 75 Months 6 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Racine Wisc

PARENTS

10. NAME OF FATHER Marshall M. Denton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Ruby Fish

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bolton, New York

14. Informant Amy R. Mitchell
(Address) Caldwell Idaho

15. Filed 11-30-, 1929- John S. Meyes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov- (Month) 28- (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929, to Nov 28, 1929

that I last saw her alive on Nov 28 1929

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Intestinal Stasis

..... (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. R. Whittenberger M. D.

Nov. 30, 1929 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: Nov- 30- 1929

20. Undertaker: S. V. Beckham — Address: Caldwell

Per WEF

Kaley RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68274

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 128

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martha F. Bartshe 46

(a) Residence. No. Caldwell R#2 St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug-7-1850

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	3	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER John Green
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Jena Hale
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Carolina

14. Informant N. W. Palmer
(Address) Caldwell R#2

15. Filed 11-27-, 1929- John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov- (Month) 22- (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1928, to Nov. 22, 1929
that I last saw her alive on Nov. 20, 1929
and that death occurred, on the date stated above, at 6:30 a.m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Peacum
..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. M. Kaley, M. D.
11-23-, 1929 (Address) Caldwell Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: Nov. 24- 1929

20. Undertaker: C. V. Peckham
Address

w.67.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Talbot

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68975

PLACE OF DEATH
County of Canyon
City of Wilder
Registration District No. 9
Primary Registration District No. 2005
Local Registrar's No. 127
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Clark Martin Jr.

(a) Residence. No. Wilder St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, ~~Married~~, ~~Widowed~~, or Divorced (~~write~~ the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 21 1929

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wilder

PARENTS

10. NAME OF FATHER William Clark Martin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Middleton
12. MAIDEN NAME OF MOTHER Viola A. Cresswell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Caldwell

14. Informant W. le. Martin
(Address)

15. Filed 11-19-, 1929. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 16, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——, 19—, to ——, 19—
that I last saw ~~him~~ alive on Nov 3, 1929
and that death occurred, on the date stated above, at 5:30 a.m.
The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? What test confirmed diagnosis?

(Signed) Robert E Talbot, M. D.
Nov 16, 1929 (Address) Wilder

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Roswell — Date of Burial: Nov-18-1929

20. Undertaker: C. V. Beckham — Address: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68277

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 125

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

205a

2. FULL NAME Rachael Ann McCall.

(a) Residence. No. 1805 Blane St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 24 1839

7. AGE Years 90 Months 5 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dayton Ohio.

PARENTS

10. NAME OF FATHER James Grisson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Burlington County New Jersey

12. MAIDEN NAME OF MOTHER Limeburner

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pennsylvania

14. Informant F. M. McCall
(Address) Caldwell Ida.

15. Filed 11-15-, 1929 - John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1917, 1917, to Nov 12, 1929
that I last saw her alive on Nov-12, 1929
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Fibroid Tumor of the Broad Ligament left side
(duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Aya
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) T. D. Forrer, M. D.
11/14, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 11/16 1929

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 11 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68278

County of Canyon
City of Middleton
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 124
(No.) 90
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elza Shellhorn

(a) Residence. No. Middleton Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alice Shellhorn.

6. DATE OF BIRTH (month, day and year) Apr 24

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	9	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Barbour Co West Virginia

PARENTS

10. NAME OF FATHER Enoch Shellhorn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia

12. MAIDEN NAME OF MOTHER Dorit Kennard

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont know

14. Informant Mrs John Stalnaker
(Address) Southwick Idaho

15. Filed 11-27-1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov - 11 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 - 1929, to Nov 11 - 1929, that I last saw him alive on Nov 11 - 1929, and that death occurred, on the date stated above, at 3-40 P. m.

The CAUSE OF DEATH* was as follows:
Complications of disease, Mitral insufficiency was the immediate cause of death

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Kidney trouble with Stomach trouble (duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None applied

(Signed) Jno Stalnaker, M. D.
12-12-1929 (Address) Middleton Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Middleton Cem	
20. Undertaker	Address
C. V. Peckham	Caldwell Ida

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68279

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005

Local Registrar's No. 123

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Andrew N. Mothorn

(a) Residence. No. 402 Chicago St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Alta C Mothorn

6. DATE OF BIRTH (month, day and year) Mch 13 1857

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	7	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner also worked in logging camps.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Davenport Iowa

PARENTS

10. NAME OF FATHER John Jacob Mothorn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Catherine Stone

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs A N Mothorn
(Address) 402 Chicago Caldwell Ida

15. Filed 11-12-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24, 1929, to Nov 9, 1929, that I last saw h alive on Nov 9, 1929, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chr. interstitial Nephritis

(duration) several yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) M. D.

11/12, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill Cemetery	Nov 12-29
20. Undertaker	**Address**
Paul L. Case	Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED DEC 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68280

PLACE OF DEATH
County of Malheur
City of Parma
Registration District No. 3
Primary Registration District No. 2007
Local Registrar's No. 10
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Michael Sauer 49

(a) Residence. No. Parma R.D. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Sauer

6. DATE OF BIRTH (month, day and year) Aug 22 1861

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Frank Sauer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Schmidt Dresse
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant John Sauer
(Address) Parma Idaho

15. Filed Dec 1, 1929 Lulu Malcolm Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1928, to Nov 21, 1929
that I last saw him alive on Nov 10, 1929
and that death occurred, on the date stated above, at 9-a m.
The CAUSE OF DEATH* was as follows:
Cancer of Prostate
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. 6 mos. — ds.

18. Where was disease contracted if not at place of death? Near Parma, Ida.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) W. J. Neese M. D.
11/30 1929 (Address) Ontario Ore.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parma Cem	11/23 1929

20. Undertaker J. V. Peckham — Address Caldwell Ida

RECEIVED DEC 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68281

PLACE OF DEATH
County of Bear Lake
City of Dingle

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101a

2. FULL NAME Roberta Quayle Lindsay.
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 23 - 1928

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	18	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dingle, Idaho.

PARENTS

10. NAME OF FATHER James Clarence Lindsay.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ovid, Idaho.
12. MAIDEN NAME OF MOTHER Mona Quayle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dingle, Idaho.

14. Informant
(Address)

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929, to Nov 24, 1929
that I last saw her alive on Nov 24, 1929
and that death occurred, on the date stated above, at 1.10 P m.
The CAUSE OF DEATH* was as follows:
Acute Lobar Pneumonia
RML & LLL
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Findings
(Signed) C O Moore, M. D.
11/25, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED DEC 10 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 68383
Registered No. 9

1. PLACE OF DEATH
County of Benewah
City of Plummer R.F.D.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

2. FULL NAME Orville Howe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 24 (Day) 1895 (Year)

7. AGE: 34 Yrs. 5 Mos. 4 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
b) General nature of inry, business, or estabment in which emyed (or employer) .....

BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Charles P. Howe

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mary Calaway

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C. P. Howe
(Address) Tekoa Wash.

15. Filed 11-25 1929 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 84 (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1929 to Nov 1929 that I last saw him alive on Nov 5 1929 and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Brain abscess

(Duration) ..... Yrs. 9 mos. ..... ds.

Contributory (Secondary) Encephalitis

(Duration) 1 Yrs. ..... mos. ..... ds.

(Signed) George A. Dawson M. D.

11-20 1929 (Address) 8308-25

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos.....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash.
DATE OF BURIAL: 11-22 1929

20. UNDERTAKER: C. L. Schulerud
ADDRESS: Tekoa Wash.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 10 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bennewah

City of Plummer, Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 46.

Primary Registration District No. 2123.

(No. ..... St.)

File No. 68283

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Seryl Dennis Hise. 16a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: Oct (Month) 30th (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 36 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business or establishment in which employed (or employer) ✓

9. BIRTHPLACE (State or Country) Plummer, Idaho.

10. NAME OF FATHER Stephen H. Hise. ~~Seryl Dennis H~~

11. BIRTHPLACE OF FATHER (State or Country) S. Carolina

12. MAIDEN NAME OF MOTHER Blanch Venn

13. BIRTHPLACE OF MOTHER (State or Country) Winona, Ill ~~S. Carolina.~~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harriet Yarber

(Address) Plummer

15. Filed Nov 1 1929 H. L. Jaeger Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 1st (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30th 1929, to Nov 1st 1929 that I last saw Baby alive on Oct 31st 1929, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Weak Heart

Congenital.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Feeble Vitality

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Herrington M. D.

11/1 1929 (Address) Wooley, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Plummer Ida

DATE OF BURIAL: 11-1 1929

20. UNDERTAKER: H. L. Jaeger

ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68284

PLACE OF DEATH

County of Canyon
City of Rural

Registration District No. 7
Primary Registration District No. 2006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 139

2. FULL NAME Nathaniel L. McCaughey —
(a) Residence. No. R.F.D. #1 St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

188e

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July - 1856

7. AGE: 73 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: ✓
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ✓
12. MAIDEN NAME OF MOTHER: Meyers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio -

14. Informant: H D Boyd
(Address) Nampa Ida Rt #1

15. Filed 11-30, 1929 Seth Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov - 27 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Crushed Chest — Automobile accident, finding of jury at inquest of Coroner.
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Paul L. Case, ~~M. D.~~
Nov. 30 - 29 (Address) Coroner — Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cem. | Date of Burial: 12-1 1929

20. Undertaker: F. K. Robinson | Address: Nampa Ida

RECEIVED JUL 17 1930

IN THE OFFICE OF THE CORONER OF

CANYON COUNTY, IDAHO

In the Matter of the Inquest of)
N. L. McCAUGHEY,) VERDICT.
Deceased.)

WE, THE JURY IN THE ABOVE ENTITLED MATTER FIND AS FOLLOWS, TO WIT:

That said N.L.McCaughey, came to his death as a result of an automobile collission between the cars of deceased and Glenn Moffat, on the evening of November, 27th,1929, at the intersection of Orchard Avenue and Midway Blvd., at about the hour of 8 o'cLock P.M., Death being instantenous and cause by crushed chest.

Foreman

Dated November,30,1929
Nampa, Idaho.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68285

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 138

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emery Otis Christian

(a) Residence. No. 1 miles so west of Nampa
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ ~~(or) WIFE of~~

6. DATE OF BIRTH (month, day and year) Aug 28 - 1889

7. AGE: Years 40 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bloomfield Mo.

PARENTS

10. NAME OF FATHER: Lewis Christian
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: Julia Scim
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Wm Christian
(Address) R#4 Nampa Ida

15. Filed 11-29, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24, 1929, to Nov 27, 1929
that I last saw him alive on Nov, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis
(duration) 3 or 4 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No.
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. C. Bell M.D.
12-2-, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Bloomfield Mo. | Date of Burial: 11-29 1929

20. Undertaker: Fred R Hinson | Address: Nampa Ida

V.C.B.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68286

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 137
(No. Samaritan Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1612

2. FULL NAME Unnamed Infant

(a) Residence. No. Queen Apts. Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) 11-22-29

7. AGE Years	Months	Days	If LESS than 1 day,
—	—	—	3 hrs. or ____ min.

8. OCCUPATION OF DECEASED —

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa, Idaho.

PARENTS

10. NAME OF FATHER Chas. Chadwell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va

12. MAIDEN NAME OF MOTHER Delpha Cope

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn

14. Informant Chas. Chadwell
(Address) Queens Apts. Idaho St.

15. Filed 11-25, 1929 Lettie Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____
that I last saw h[illegible] alive on Nov 22, 1929
and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity and Patent foramen ovale (Blue baby)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. H. Proctor, M. D.

11-26, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Idaho	11-25 1929
20. Undertaker	**Address**
Fred H. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68287

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. [redacted] Samaritan Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 136

140

2. FULL NAME Reuben Jacob Freeman

(a) Residence. No. 511 Hobley St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ersie Freeman

6. DATE OF BIRTH (month, day and year) Feb. 17th 1866

7. AGE	Years	Months	Days	If LESS than 1 day,
	63	9	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer self

9. BIRTHPLACE (city or town) Ashley
(State or country) Illinois

PARENTS

10. NAME OF FATHER Elisar N. Freeman
11. BIRTHPLACE OF FATHER (city or town) Ashley
(State or Country) Illinois
12. MAIDEN NAME OF MOTHER Sidney Jane Wheeler
13. BIRTHPLACE OF MOTHER (city or town) Ashley
(State or Country) Illinois

14. Informant Mrs. Ersie Freeman
(Address) Nampa Idaho

15. Filed 11-29, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1929 to Nov 25, 1929
that I last saw him alive on Nov. 25, 1929
and that death occurred, on the date stated above, at 7 : 15 P. m.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Left side paralyzed)
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Wm. E. Haynes, M. D.
Nov. 27, 1929 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlelawn-Nampa	11-29 1929
20. Undertaker	Address
Wm D. Talbot	Nampa, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 1 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68288

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 135
(No. 207 - 9th Ave. So)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wiley Henderson Ulliver

(a) Residence. No. 207 - 9th ave. So St.
(Usual place of abode)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Lydia Ulliver

6. DATE OF BIRTH (month, day and year) April 12th 1862

7. AGE

Years	Months	Days	If LESS than 1 day,
67	7	12	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10. NAME OF FATHER: — Ulliver
11. BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): North Carolina

14. Informant: Mrs. Lydia Ulliver
(Address) 207 - 9th ave. So. Nampa, Ida.

15. Filed 11-26, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 24th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1926 to Nov 24, 1929
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:
Clinical diagnosis Pulmonary Tuberculosis both lungs T.B not found (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) — 2
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & X-Ray
(Signed) Ross R Proctor M. D.
11-26, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Konkelaun-Nampa	11 - 27 1929
20. Undertaker	Address
Wm D. Fall	Nampa Ida.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68289

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 134

2. FULL NAME Agostina Corda 57

(a) Residence. No. 1317 - 7th St. So. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. unknown 1870

7. AGE Years 59 Months 2 Days If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10. NAME OF FATHER: Francesco Galacci
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Italy
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy

14. Informant: Mr.
(Address) Nampa, Idaho

15. Filed 11-24, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ___, 19___, to Nov 20, 1929
that I last saw her alive on Nov 20, 1929
and that death occurred, on the date stated above, at 1:30 P. m.
The CAUSE OF DEATH* was as follows:
Diabetic Acidosis and Uraemia
(duration) 3 yrs. ___ mos. 7 ds.

CONTRIBUTORY (Secondary) (Fracture hip Sept 2) Heated
(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Reduce fracture Date of Sept 4/29
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
11/21, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mt Calvary - Nampa
Date of Burial: 11-25 1929

20. Undertaker: Mrs. Nina N. Talley
Address: Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68290

RECEIVED DEC 11 1929

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 133

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ella Wilterding

(a) Residence. No. 106-12 ave S St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 16 1860

7. AGE: Years 69 | Months 8 | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: E. G. Purdum
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Md
12. MAIDEN NAME OF MOTHER: Lucinda Benton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14. Informant: Della M. Fordyce
(Address) 221 - N. 7th St Cambridge, O.

15. Filed Nov 23, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Nov. 19, 1929
that I last saw her alive on Nov 19, 1929
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows:
Spinal sclerosis
Progressive, with paralysis
Muscles & respiration
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) V C Beeking M. D.
Nov 22, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fred R Robinson | Date of Burial: 11-22 1929

20. Undertaker: R Oberlown Cem | Address: Nampa

CB

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68291

Local Registrar's No. 131

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 2006

(No. 1½ mi. east Nampa)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charlotte Olsen

(a) Residence. No. 1½ miles east Nampa St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of B. P. Olsen

6. DATE OF BIRTH (month, day and year) April 19th 1855

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work house wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER John Johanson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mr. B. P. Olsen

(Address) Nampa, Idaho

15. Filed 11-20, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 18th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to Nov 18, 1929, that I last saw her alive on Sept 10, 1929, and that death occurred, on the date stated above, at 4:15 p.m.

The CAUSE OF DEATH* was as follows: Chronic Brights Disease

5 & 10 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V. C. Rulon M. D.

11-20, 1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn - Nampa	11-20 1929
20. Undertaker	Address
Mrs. Nina M. Talley	Nampa, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68392

RECEIVED DEC 11 1929

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 13

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Wesley Herrin

(a) Residence. No. West 1½ miles St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) ~~WIFE of~~ Bell C. Herrin

6. DATE OF BIRTH (month, day and year) Oct-5-1853

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) (Retired)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Moses Herrin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill
12. MAIDEN NAME OF MOTHER Mary J. Pierce
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill

14. Informant Mrs Bell C Herrin
(Address) Route #1. Nampa Ida

15. Filed Nov 30, 1929 Leetha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14, 1929, to Nov 18, 1929
that I last saw him alive on Nov 17, 1929
and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:
Hemorrhage brain.
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Horace P Rutherford M. D.
11/18, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem	11-20 1929
20. Undertaker	Address
Fred K Robinson	Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
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RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68293

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
(No. 11th Ave & 6th St N)
Local Registrar's No. 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dora May Graves

(a) Residence. No. 11 Ave & 6th St N St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Sylvester Vermilliam
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Daniel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant
(Address)

15. Filed 11-19, 1929 Stella Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-12, 1929 to 11-17, 1929 that I last saw her alive on 11-16, 1929 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows: Diabetes Mellitus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinic Symptoms

(Signed) J. C. Horton, M. D.
11-18, 1929 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem	11-19 1929
20. Undertaker	Address
Fred K. Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68294

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 128
(No. Samaritan Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1006a

2. FULL NAME Frank Luba

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 58			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) ..... (State or country) .....

PARENTS

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (city or town) ..... (State or Country) .....

14. Informant Dr O. A. Swayne
(Address) Nampa, Ida

15. Filed 11-17, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6, 1929, to Nov 14, 1929
that I last saw him alive on Nov 14, 1929
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy

(Signed) O. A. Swayne M. D.
Nov 16, 1929 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa, Ida.	11-18 1929

20. Undertaker Fred K. Robinson Address Nampa Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH RECEIVED DEC 1 1 1929

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006

DO NOT WRITE IN THIS SPACE
State File No. 68295

Local Registrar's No. 127

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Perry Kellar

(a) Residence. No. 302 - Fern St St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

48B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Albert Kellar
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant D. B.
(Address)

15. Filed 11-22, 1929 Ruth Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-13, 1929, to 11-17, 1929
that I last saw him alive on 11-16, 1929
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows:

Myocarditis.

not known (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J. C. Horton M. D.
11-21, 1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverview Cem	11-17 1929
20. Undertaker	Address
E. R. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

14

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68296

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 126
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME Peter O. Carlberg
(a) Residence. No. 9th ave + 2d St N St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Feb 2 - 1854

7. AGE Years: 75 Months: 9 Days: 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Well Driller
(b) General nature of industry, business, or establishment in which employed (or employer) (retired)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant Mrs Edna Gardner
(Address) Sweet, Idaho

15. Filed 11-16, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Probably heart attack fell dead on street no post mortem exam.
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Instant Death
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) O C Bellman M. D.
11-14-, 1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa, Ida
Date of Burial: 11-16 1929

20. Undertaker: F. K. Robinson
Address: Nampa Ida

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68297

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 125
(No. 2 miles south Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1012

2. FULL NAME Roy Prewett

(a) Residence. No. 2 mi. south Nampa St.
(Usual place of abode)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 25th 1913

7. AGE	Years	Months	Days	If LESS than 1 day,
	16	1	15	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work school boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Dixon
(State or country) Montana

PARENTS

10. NAME OF FATHER W. P. Prewett
11. BIRTHPLACE OF FATHER (city or town) Texas
(State or Country)
12. MAIDEN NAME OF MOTHER Jessie Foust
13. BIRTHPLACE OF MOTHER (city or town) Black Hills
(State or Country) So. Dakota

14. Informant W. P. Prewett
(Address) Nampa, Idaho

15. Filed 11-16, 1929 Lester Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 15th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
11-9, 1929, to 11-15, 1929
that I last saw him alive on 11-15, 1929
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Catarrhal Pneumonia ~~Facio~~

(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Haemorrhagic Variola
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) A. E. Robinson, M. D.
11-16, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	11-16 1929
20. Undertaker	Address
Wm D Talley	Nampa, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68998

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 2006 Nampa

Local Registrar's No. 124

(No. 3 mi north Nampa)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John M. Hendricks

(a) Residence. No. 3 mi. north Nampa St.

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Georgia Hendricks

6. DATE OF BIRTH (month, day and year) June 12th 1875

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	54	4	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Michael Hendricks

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Francis Maxwell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mrs. Georgia Hendricks

(Address) Nampa Idaho.

15. Filed 12-9, 1929 Martha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24, 1924 to Nov 8, 1929

that I last saw h. in alive on Nov. 8, 1929

and that death occurred, on the date stated above, at 10:30P m.

The CAUSE OF DEATH* was as follows: Cysto Myelitis. Spinal (.)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C E Bellman M. D.

12-1, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. Calvary - Nampa	12-11 1929
20. Undertaker	Address
Wm D. Talley	Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68299

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 123

(No. 839 - 11th Ave. No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME August Papez

(a) Residence. No. 839 - 11th Ave. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Isabel Papez

6. DATE OF BIRTH (month, day and year): Sept. 5th 1860

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	2	5	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: rancher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Europe

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Mrs. Isabel Papez
(Address): Nampa, Idaho

15. Filed 11-10, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 9th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ....., M. D.

....., 19..... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa

Date of Burial: 11-10 1929

20. Undertaker: Wm D. Fall

Address: Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68300

PLACE OF DEATH

County of Canyon
City of Rural

Registration District No. 7
Primary Registration District No. 2006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 122

90

2. FULL NAME John C. Jennings
(a) Residence. No. Boise, Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 29 - 1850

7. AGE Years 79 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) (retired)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tenn

PARENTS

10. NAME OF FATHER James Jennings
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Mrs Hugh Yaryan
(Address) Nampa, Idaho

15. Filed 11-8, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1925, to Nov 7th, 1929
that I last saw him alive on Nov 7th, 1929
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows: Chronic Valvular Heart disease
(duration) 10? yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis
(duration) 10? yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical signs
(Signed) H. P. Ross, M. D.
Nov 8, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Boise Ida — Date of Burial: 11-9 1929

20. Undertaker: Fred F. Robinson — Address: Nampa Ida

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

~~DO NOT~~ WRITE IN THIS SPACE
State File No. 68301

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
(No. 4½ mi south Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 121

2. FULL NAME Richard Rush Smith 74a
(a) Residence. No. 4½ mi south Nampa St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug — 1853

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
76	2	unknown	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Date Michigan

PARENTS

10. NAME OF FATHER: Sanford M. Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Michigan
12. MAIDEN NAME OF MOTHER: Katherine Rowley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Mr. Garrett Smith
(Address) Nampa, Idaho

15. Filed 11-6, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 5th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1929, to Nov 5, 1929
that I last saw him alive on Nov 5, 1929
and that death occurred, on the date stated above, at 10:35 P. m.
The CAUSE OF DEATH* was as follows:
Haemorrhage in brain
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical.
(Signed) Horace P. Bilhard, M. D.
Nov 5, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa
Date of Burial: 11-7th 1929

20. Undertaker: Wm D. Talley
Address: Nampa, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68[illegible]

PLACE OF DEATH
County of Canyon
City of Rural
Registration District No. 7
Primary Registration District No. 2016
(No. —)
Local Registrar's No. 119

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emily C Chase 90

(a) Residence. No. 5 - Miles North of Nampa St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Chase

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER John Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Maryjane Standley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs. E. J. Perkins
(Address) Nampa Ida.

15. Filed 11-6, 1929 Ruth Cooney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23, 1929, to Nov 4, 1929
that I last saw her alive on Nov 4, 1929
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows: Acute dilation of heart
Five minutes (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) Years yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Frank P Bell M. D.
Nov. 6, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial 19
Rigby Idaho	
20. Undertaker	Address
F. K. Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REC'D DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68304

PLACE OF DEATH
County of Caribou
City of Conda
Registration District No. 82
Primary Registration District No. 7-159
Local Registrar's No. 29
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mariantha Athay Lindsay

(a) Residence. No. St. Paris, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Philemon Lindsay

6. DATE OF BIRTH (month, day and year) July 25, 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	4	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer 0

9. BIRTHPLACE (city or town) (State or country) London, England

PARENTS

10. NAME OF FATHER James B. Athay
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Ellen Morris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Willard Lindsay
(Address) Conda, Idaho

15. Filed Nov 26, 1929 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1929, to Nov. 25, 1929
that I last saw her alive on Nov. 25, 1929
and that death occurred, on the date stated above, at 5:00 P. m.
The CAUSE OF DEATH* was as follows:

Diabetes Mellitus
(duration) 14 yrs. mos. ds.
CONTRIBUTORY (Secondary) Diabetic Gangrene
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Paris, Idaho
Did an operation precede death? No Date of 0
Was there an autopsy? No
What test confirmed diagnosis? Chem. Exp. urine
(Signed) Russell Tigert, M. D.
Nov. 26, 1929 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial~~, Cremation, or Removal	Date of Burial
Paris Idaho	11/29 1929

20. Undertaker	Address
F. M. Williams	Montpelier Idaho

REC... DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68395

PLACE OF DEATH
County of Bonneville
City of Soda Springs

Registration District No.
Primary Registration District No.
Local Registrar's No. 28

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Francis Haggerty

(a) Residence. No. Soda Springs St. Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Oct. 12 - 1865

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	64	1	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Paul Minn

PARENTS

10. NAME OF FATHER Patrick Haggerty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.
12. MAIDEN NAME OF MOTHER Mary McAndrews.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant John P Haggerty
(Address) Soda Springs, Ida

15. Filed 11-20, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1929, to Nov. 20, 1929
that I last saw him alive on Nov. 20, 1929
and that death occurred, on the date stated above, at 11:20 a m.
The CAUSE OF DEATH* was as follows:
Gastric ulcer (Perforated)
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? same
Did an operation precede death? No Date of 0
Was there an autopsy? No
What test confirmed diagnosis? Phys. & Symptl.
(Signed) Russell Sigert, M. D.
11-20-, 1929 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello Ida	11-23-1929
20. Undertaker E L Whitman	Address Soda Springs Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68306

Registration District No.
Primary Registration District No.
Local Registrar's No. 27

PLACE OF DEATH

County of Caribou
City of Soda Springs

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George William Blackburn

(a) Residence. No. Soda Springs Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Married to Blackburn

6. DATE OF BIRTH (month, day and year): Apr. 10-1862

7. AGE

Years	Months	Days	If LESS than 1 day,
67	6	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Falls City Neb.

PARENTS

10. NAME OF FATHER: George William Blackburn
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Dublin Ireland
12. MAIDEN NAME OF MOTHER: Jane E. Dickerson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: Joe F. Blackburn
(Address) Soda Springs Ida.

15. Filed 11-4-1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7, 1926, to Nov 2, 1929
that I last saw h[illegible] alive on Nov 2, 1929
and that death occurred, on the date stated above, at 5 a.m.
The CAUSE OF DEATH* was as follows:
Valvula Heart Disease
Mitral Stenosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) 0
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? 0 Date of 0
Was there an autopsy? 0
What test confirmed diagnosis? Examination

(Signed) Emil K. Erb M. D.
11-4, 1929 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Soda Springs Ida	11-4 1929
20. Undertaker: C. D. Wilkerson	Address: Soda Springs Ida

RECEIVED DEC 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68307

PLACE OF DEATH
County of Cassia
City of Burley
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Williams

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

101 B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE	Years	Months	Days	If LESS than 1 day,
	About 43	years		hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant D.E. Johnson
(Address) Burley Ida

15. Filed 11-26, 1929 F. W. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 31st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1929, to Oct 31, 1929
that I last saw h[illegible] alive on Oct 30. 1929
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Pneumonia.

(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Symptoms
(Signed) D.E. Johnson, M. D.
Oct. 31, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Nov. 12 1929
20. Undertaker D. E. Johnson	Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68308

PLACE OF DEATH

County of .....

City of .....

Registration District No. .....

Primary Registration District No. .....

Local Registrar's No. .....

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Axel Francis Oscar Nielson 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 25, 1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	61		6	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Doctor M.D.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Jacob Nielson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Sophia Johanson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant .....

(Address) .....

15. Filed 11-26-, 1929 F. H. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 31st 1929,
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 29th, 1929, to Oct 31st, 1929, that I last saw him alive on Oct. 31st, 1929, and that death occurred, on the date stated above, at — 11 am

The CAUSE OF DEATH* was as follows:

Heart disease.

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Haemorrhage

..... (duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? ✓

(Signed) G. H. Cooper, M. D.

....., 19..... (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

RECEIVED DEC 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68309

PLACE OF DEATH

County of Cassia
City of Burley
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Charles Fisher

133

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 1 1844

7. AGE	Years	Months	Days	If LESS than 1 day,
	85	4	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS

10. NAME OF FATHER Joseph Fisher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Molane
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Frank M Fisher
(Address) Burley Idaho.

15. Filed 11-26, 1929 F. H Carter
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18, 1929, to Oct 18, 1929
that I last saw h alive on, 19
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:

Malegnat Growth of Bladder
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) F H Carter, M. D.
Oct 25, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Declo Idaho.	Oct. 23 1929

20. Undertaker D. E. Johnson	Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65316

PLACE OF DEATH
County of Cassia
City of Burley
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Stephenson Colbert

90

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 5 1875

7. AGE

Years	Months	Days	If LESS than 1 day,
53	11	14	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Iron Molder
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Salt Lake City Utah

PARENTS

10. NAME OF FATHER: John S Colbert
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Sarah Fitt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: George A Page
(Address): Woods Cross Utah.

15. Filed 11-26, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D. E. Johnson County Coroner, M. D.
, 19 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	19
20. Undertaker D. E. Johnson	Address Burley

RECEIVED DEC 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68311

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

126

2. FULL NAME Justina Rombach

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 2 1852

7. AGE Years 77 Months 2 Days 13 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Richard Rombach
(Address) Burley Idaho. R.F.D.$

15. Filed Nov 26, 1929 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 15 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11th, 1929, to Oct 14, 1929
that I last saw her alive on Oct 13, 1929
and that death occurred, on the date stated above, at 5:30 A m.
The CAUSE OF DEATH* was as follows:
~~Ruptured Gall Bladder~~
Peritonitis
(duration) yrs. 10 mos. 4 ds.
CONTRIBUTORY (Secondary) Ruptured Gall Bladder Peritonitis
Suffered a fall on the doorstep of her house causing rupture of gall bladder
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? bladder.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) F. H. Cutler, M. D.
Oct. 17, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida
Date of Burial Oct 20 1929

20. Undertaker D. E. Johnson
Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 23 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

68311

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Dr. F.H. Cutler
Burley

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Justina Romback who died at Burley, Idaho on Oct. 15, 1929
Cause of death given as "Peritonitis. Ruptured Gall Bladder."

Information DESIRED in order to complete certificate:

PLEASE STATE CAUSE OF RUPTURE OF GALL BLADDER.

PLEASE ANSWER BELOW:

Patient suffred a fall on the doorstep of her house which caused the Rupture of the Gall Bladder

F J H Cutler MD.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68312

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2187

Local Registrar's No. 107

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas Lewis 90

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 59			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Clearwater Timber Co

9. BIRTHPLACE (city or town) (State or country) ?

PARENTS

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ?

14. Informant W. A. Shaw Coroner
(Address) Orofino Ida

15. Filed Nov 10, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 10 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at About 9 A.M.

The CAUSE OF DEATH* was as follows:

Found dead in bed at Clearwater Timber Co bunk House Valvor Heart D

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. A. Shaw Coroner, M. D.

Nov 10, 1929 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Nov 13 1929

20. Undertaker	Address
W. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 6 1929

PLACE OF DEATH

County of Clearwater

City of Pierce

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 2187

(No.) 90

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 68313

Local Registrar's No. 168

2. FULL NAME Frank Fitz

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Sinle

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 12 1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Minner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Main

PARENTS

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ?

14. Informant W. A. Shaw Coroner
(Address) Orofino

15. Filed 11/27, 1929. W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 27 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 12:30 ∞ m.

The CAUSE OF DEATH* was as follows:

Fell dead out in the yard
Valvor Heart Dease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. Shaw Coroner, M. D.

11/27, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pierce Ida	11/29 1929

20. Undertaker	Address
W. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68314

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 109

2. FULL NAME Benjamin Dizer Burton 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ina Cook Burton

6. DATE OF BIRTH (month, day and year): Dec 12th 1891

7. AGE: ~~37~~ Years 37 Months 11 Days 13 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer): Clearwater Timber Co.
(c) Name of employer: Clearwater T. Co.

9. BIRTHPLACE (city or town) (State or country): Paris Mo.

PARENTS

10. NAME OF FATHER: H. C. Burton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
~~Sarah C. Brown~~
12. MAIDEN NAME OF MOTHER: Sarah C Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ky.

14. Informant: W. M. Burton
(Address): St Marie Ida

15. Filed 11/28, 19.... W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24, 1929, to Nov 25, 1929
that I last saw him alive on Nov 25, 1929
and that death occurred, on the date stated above, at 8:30 P m.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
"Heart Block" & Nephritis
Years (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Ptomaine Poisoning
1 (duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? Ptomaine Pierce
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) W. F. Robertson, M. D.
11-27, 1929 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Marie — Date of Burial: 11/30 1929

20. Undertaker: W. D. Pinson — Address: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68315

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 70
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 110

2. FULL NAME John A. McKay

(a) Residence. No. 16 St. Coeur d'Alene, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? 29 yrs. + mos. + ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of

6. DATE OF BIRTH (month, day and year) September 13, 1884

7. AGE	Years	Months	Days	If LESS than 1 day,
	45	2	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work "Railroading"-
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kingston, Ontario, Canada.

PARENTS

10. NAME OF FATHER J. A. McKay

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ontario, Canada.

12. MAIDEN NAME OF MOTHER Annie Elizabeth DeRoche

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed 11/30, 1929. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7th, 1928, to November 30 1929
that I last saw him alive on November 29, 1929
and that death occurred, on the date stated above, at 4.15 A. m.

The CAUSE OF DEATH* was as follows:
General paralysis of the insane.

(duration) + yrs. + mos. + ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory - Wassermann

(Signed) John Irvine McKelvey, M. D.
Nov. 30 1929 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Coeur d'Alene, Idaho	

20. Undertaker — Address
Orofino Mortuary Orofino, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

NOV 19 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Custer

City of Mackay

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 76

Primary Registration District No. 2153

(No. ....., ... St.)

File No. 68316

Registered No. 121

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roy Peck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Am

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 4 (Day) 1872 (Year)

7. AGE: 57 Yrs. 7 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher & Live Stock

(b) General nature of industry, business or establishment in which employed (or employer): Live Stock

9. BIRTHPLACE (State or Country): Salt Lake City Utah

10. NAME OF FATHER: William P. Peck

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Peck

(Address) Ogden Ut

15. Filed Nov. 14 1929 Rose Nowak
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/3/29 19..., to 11/3/29 19..., that I last saw him alive on 11/3/29 19..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carroll A B Jensen M. D.

11/4 1929 (Address) Mackay Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Farmington Utah

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Theo R. Garmin

ADDRESS: Mackay

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 19 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 76

County of Custer

Primary Registration District No. 2153

File No. 6831

City of Mackay

(No. ....., ... St.)

Registered No. 120

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Rocha

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Wh.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unknown (Month) 1 (Day) (Year)

7. AGE: 63 about. Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Quartz Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): France

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D.A. Brieker
(Address) Mackay Idaho

15. Filed Nov 14 1929 Ros Nowacki Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, ~~That I attended~~ deceased from Died on road 191 , ~~to~~ from mine to Hospital 191 , ~~that I last saw him~~ lived ~~alive on~~ 5 hrs after accident; ~~and that~~ death occured on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows: ~~Did not see him before death~~
Shock - Hemorrhage;
Fractured Knee; Tibia
accidental from careing Ore in Mine
Sawbody (~~Duration~~) 2 hrs. ~~Yrs.~~ after ~~mos.~~ death; ds,
Contributory (Secondary) Hemorrhage from femoral Veins
Large branches of artery (F)
(Duration 5 hrs. yrs. mos. ds.

(Signed) H. A. Richards M. D.
11/11/29 (Address) Mackay, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mackay, Idaho
DATE OF BURIAL: 11/2/29 191

20. UNDERTAKER: Geo. R. Jarmain
ADDRESS: Mackay, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

RECEIVED NOV 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68318

PLACE OF DEATH
County of Custer
City of Mackay

Registration District No. 16
Primary Registration District No. 3153
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 119

129

2. FULL NAME John Hague
(a) Residence. No. Clayton, Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6. DATE OF BIRTH (month, day and year)

7. AGE Years About 69 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) Mining
(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant W. Brockman
(Address) Mackay, Idaho

15. Filed Nov. 14, 1929 Rose Nowacki Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/1/29, 19..., to 10/8/29, 19...
that I last saw him alive on 10/8/29, 19...
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Osteo-Myelitis; Traumatic:-Abcess or Cellulitis of Foot.
(duration) 1 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Nephritis; Chronic
(duration) — yrs. 2 mos. — ds.

18. Where was disease contracted if not at place of death? Challis, Idaho
Did an operation precede death? Yes Date of 9/2/29 - 10/1/29
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs; Chemical
(Signed) F. P. Richards, M. D.
10/9/29, 19... (Address) Mackay Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt. McCaleb Mackay, Ida Date of Burial Oct 9 1929

20. Undertaker Theo. R. Garnier Address Mackay

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68219

PLACE OF DEATH

County of Custer
City of Mackay

Registration District No. 16
Primary Registration District No. 2153

Local Registrar's No. 118

(No.) 41
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Bauman McKenny

(a) Residence. No. Challis St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of George McKenny

6. DATE OF BIRTH (month, day and year) June 1st 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	4	3	x hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) x

(c) Name of employer x

9. BIRTHPLACE (city or town) (State or country) Ogden, Utah

PARENTS

10. NAME OF FATHER x Bauman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. J. McKenney
(Address) Challis Idaho

15. Filed Nov. 14, 1929 Rose Newacheck Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/30/29, 19..., to 10/4/29, 19...
that I last saw h[er] alive on 10/4/29, 19...
and that death occurred, on the date stated above, at 9:00 P. m.
The CAUSE OF DEATH* was as follows:

Infected Ulcer of Leg: Varicose. (Toxemia)

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 10 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? Challis, Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? — Chemical: Physical

(Signed) F. P. Wilcox M. D.
10/5/29, 19... (Address) Mackay Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mackay Idaho	Oct. 7 1929
20. Undertaker	Address
Leo A. Garnier	Mackay

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 19 1929

PLACE OF DEATH

County of Custer

City of Mackay

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 16

Primary Registration District No. 2153

(No. 185)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68320

Local Registrar's No. 117

2. FULL NAME Mike Smith

(a) Residence. No. Mackay, Ida St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White ~~Austrian~~	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6. DATE OF BIRTH (month, day and year) XXXXXX unknown

7. AGE Years	Months	Days	If LESS than 1 day,
about 58	~~XX~~	~~XXX~~	~~XXXX~~ hrs. or ~~XXXX~~ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer) Mining

(c) Name of employer ~~Chase A Clark~~ Mackay Metals

9. BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) XXXXXX unknown

12. MAIDEN NAME OF MOTHER unknown Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) XXXXXX

14. Informant Chas A. Clark

(Address) Mackay, Idaho

15. Filed Nov. 14, 1929 Rose Nowack Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/4/29, 19..., to 10/4/29, 19...

that I last saw h~~im~~ alive on 10/4/29, 19...

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Fracture Base Skull; Shock.
(From accidental Fall).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/4/29

Was there an autopsy? No

What test confirmed diagnosis? Symptoms - P. P.

(Signed) H. C. Richards, M. D.

10-5-29, 19... (Address) Mackay Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mackay Cem. Mackay Idaho	March 6 1929

20. Undertaker Address

Leo D. Garnick Mackay

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68321

PLACE OF DEATH
County of Custer
City of Mackay

Registration District No. 76
Primary Registration District No. 2153
(No. 74a
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 116

2. FULL NAME Ruth Stout

(a) Residence. No. ..... St. Mackay
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of James A Stout

6. DATE OF BIRTH (month, day and year) Aug 1 1872

7. AGE Years 57 Months 1 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah - Plain City

PARENTS

10. NAME OF FATHER Al-Richardson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~~[illegible]~~ Missouri
12. MAIDEN NAME OF MOTHER Alice Anna - Warta
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Jos J Matthews
(Address)

15. Filed Nov 14, 1929 Rose Nowacki Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/31, 1929, to 8/31, 1929
that I last saw her alive on 9/31, 1929
and that death occurred, on the date stated above, at 1045 P m.
The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Carroll A B Johnson, M. D.
....., 19..... (Address) Mackay Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery
Date of Burial: 9/31 1929

20. Undertaker: Wm C Hackle
Address: Salmon Ida

RECEIVED NOV 1 0 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68322

PLACE OF DEATH
County of Custer
City of Mackay

Registration District No. 7
Primary Registration District No. 3153
Local Registrar's No. 115

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Mutz

(a) Residence. No. Mackay, c Ida St. (Usual place of abode)
Length of residence in city or town where death occurred 19 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	W.	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Mutz.

6. DATE OF BIRTH (month, day and year) June 8, 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	1	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer X

9. BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10. NAME OF FATHER Wm. Mutz Sr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Mrs Jacob Mullong
(Address) Mackay Ida

15. Filed Nov. 14, 1929 Rose Nowacki Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 21 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/19/29, 19, to 7/21/29, 19
that I last saw him alive on 7/21/29, 19
and that death occurred, on the date stated above, at 11.30 P m.
The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic
(duration) 1 yrs. - mos. - ds.
CONTRIBUTORY (Secondary) Intestinal Obstruction: Illius,
(Toxemia) Paralytic: (duration) - yrs. - mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Symptoms.
(Signed) F. V. Richards, M. D.
7/23/29, 19 (Address) Mackay Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
~~Mackay~~ Basin Montana	July 25 19 29
20. Undertaker	Address
Theo. R. Garmin	Mackay, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 19 1929

PLACE OF DEATH

County of Custer

City of Mackay

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 16

Primary Registration District No. 2153

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68323

Local Registrar's No. 114

128

2. FULL NAME William Faraday

(a) Residence. No. Mackay, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 63 yrs. X mos. X ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day and year) unknown

7. AGE

Years	Months	Days	If LESS than 1 day,
63	X	X	X hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mining prospector

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9. BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Theo R. Garnier

(Address) Mackay, Ida.

15. Filed Nov. 14, 1929. Rose Nowacki
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~X~~ 6-23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/17, 1929, to 6/22, 1929

that I last saw him alive on 6/22, 1929

and that death occurred, on the date stated above, at 1 17 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Carroll G. B. [illegible] M. D.

....., 19..... (Address) Nebeky [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mackay, Idaho

Date of Burial June 24 1929

20. Undertaker Theo R. Garnier

Address Mackay, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68324

PLACE OF DEATH
County of Franklin
City of Preston Idaho

Registration District No. 27
Primary Registration District No. 2119
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. ....

46

2. FULL NAME Anna E. Nelson

(a) Residence. No. .... St. ....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Hanse Nelson

6. DATE OF BIRTH (month, day and year) June 7 1856

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	73	4	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Otto Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER K. Sophia Hansen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Hanse C. Nelson
(Address) Preston Idaho

15. Filed Nov. 7, 1929. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Oct. 30, 1929
that I last saw her alive on Oct. 20, 1929
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Sigmoid
.... (duration) Don't know yrs. Don't know ds.

CONTRIBUTORY (Secondary) ....
.... (duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? No Date of ....
Was there an autopsy? No
What test confirmed diagnosis? X-ray

(Signed) G. W. Hatheward, M. D.
Oct. 31, 1929 (Address) Logan Utah

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Minkcreek Idaho	Nov 3 1929

20. Undertaker M. W. Hendricks Address Preston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 7 1929

PLACE OF DEATH

County of Franklin

City of Preston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 27

Primary Registration District No. 2119

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 68325

Local Registrar's No. .....

179

2. FULL NAME Mary Ann Wilcox

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. A. Wilcox

6. DATE OF BIRTH (month, day and year): Mar 3 1854

7. AGE: Years 75, Months 8, Days 12. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: Jeremiah Terrall

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Ann Webb

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Geo. A Wilcox
(Address) Preston Idaho

15. Filed Dec. 4, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-13, 1929, to 11-16, 1929

that I last saw her alive on 11-16, 1929

and that death occurred, on the date stated above, at 12:15 a m.

The CAUSE OF DEATH* was as follows:

Shock from severe burns - caught fire by sweeping leaves onto bonfire which ignited her clothes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [signature], M. D.

11-18, 1929 (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho

Date of Burial: Nov. 18 1929

20. Undertaker: M.W. Hendricks

Address: Preston

RECEIVED OCT 22 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68325

Dr. A.R. Cutler
Preston

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Mary Ann Wilcox who died at Preston, Idaho on Nov. 16, 1929
Cause of death given as "Shock from severe burns."

Information DESIRED in order to complete certificate:

IF A BURNING BUILDING WAS INVOLVED PLEASE STATE THE FACT, AS THESE CASES ARE SEPERATELY CLASSIFIED.

PLEASE ANSWER BELOW:

Oct. 20

Dear Sir:

This woman caught fire by sweeping leaves on to a bonefire which ignited her clothes.

A. P. Cutler

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 7 1929

PLACE OF DEATH

County of Franklin

City of Preston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 68326

Local Registrar's No.

2. FULL NAME Lois Harriet Jenden

57

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 4 1920

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	2	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: school girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston Idaho

PARENTS

10. NAME OF FATHER James Jensen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lago Idaho

12. MAIDEN NAME OF MOTHER Amanda Sorensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mantua Utah

14. Informant James Jensen

(Address) Preston Idaho

15. Filed Dec. 2, 1929 A. R. Chesley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1st, 1928, to Nov 29, 1929

that I last saw her alive on Nov 29, 1929

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sugar in Blood & Urine

(Signed) Eugene Worley, M. D.

Nov. 29, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Dec. 3 1929

20. Undertaker	Address
M. W. Hendricks	Preston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68327

PLACE OF DEATH
County of Franklin
City of Weston
Registration District No. 27
Primary Registration District No. 2119
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Hanna Mary Jensen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm/ Jensen

6. DATE OF BIRTH (month, day and year) July 30 1849

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	3	II	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Jense C. Nellsen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Margurett Hansen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmaerk

14. Informant Wm. Jensen
(Address) Weston Idaho

15. Filed Dec 4, 1929 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Nov 10, 1929, that I last saw her alive on Nov 10, 1929, and that death occurred, on the date stated above, at 5-10A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Weston Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Thos D Holder, M. D.
11/12, 1929 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Weston Idaho	Nov 13 '29

20. Undertaker	Address
MW Hendricks	Preston Idaho

RECEIVED DEC 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68328

PLACE OF DEATH
County of Franklin
City of Clifton
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Nelson Howell

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth B. Howell

6. DATE OF BIRTH (month, day and year) May 23 1840

7. AGE	Years	Months	Days	If LESS than 1 day,
	89	5	15	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Memphis Tenn

PARENTS

10. NAME OF FATHER Thomas C.D.Howell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn;
12. MAIDEN NAME OF MOTHER Sarah Walace
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Elizabeth B. Howell
(Address) Clifton Idaho

15. Filed Dec. 4, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1929 to Sept-30, 1929 that I last saw h[illegible] alive on Sept-30, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Prostatic Inflamation of 2 months duration

(duration) - yrs. 2 mos. - ds.

CONTRIBUTORY (Secondary) General Debility from age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) G. W. States, M. D.
Nov. 11, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clifton Idaho	Nov. 12 1929

20. Undertaker	Address
MWHendricks	Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68329

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Fremont
City of Ashton

Registration District No. 102
Primary Registration District No. 6
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Nodine Carson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day and year) 11-25-29

7 AGE Years | Months | Days: one | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country): Ashton, Ida.

PARENTS
10 NAME OF FATHER: Wm E. Carson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Idaho.
12 MAIDEN NAME OF MOTHER: Sara Ryset Carson
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Idaho.

14 Informant: Sara Ryset Carson
(Address) Ashton, Ida.

15 Filed 11-26, 1929 C. A. Meacham
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 11 (Month) 26 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 11-25, 1929, to 11-26, 1929, that I last saw her alive on 11-26, 1929, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Hypertrophied Thymus.
..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary): D. K.
✓ (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no.
What test confirmed diagnosis? none
(Signed) C. A. Meacham, M. D.
11-26, 1929. (Address) Ashton, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Near Ida Falls, Ida. | Date of Burial: 11-27 1929

20. Undertaker: L. Kiser | Address: Ashton Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68339

PLACE OF DEATH

County of Fremont
City of Ashton

CERTIFICATE OF DEATH

Registration District No. 102
Primary Registration District No. 6
(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Otis Lyle Harris

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. 8th 1929

7 AGE: Years - | Months - | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ashton Idaho

PARENTS

10 NAME OF FATHER W.O. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Henry? Idaho

12 MAIDEN NAME OF MOTHER Lyle Carson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa Tama

14 Informant W.O. Harris
(Address) Ashton Idaho

15 Filed 12-9, 1929 A.M. Meacham
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
December. 9. 1929
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1929, to Dec 9, 1929
that I last saw him alive on Dec 9, 1929
and that death occurred, on the date stated above, at 9:10 P.M.

The CAUSE OF DEATH* was as follows:
Failure of Closure of Foramen Ovale

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) V-T

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) A.M. Meacham, M. D.
12-9, 1929 (Address) Ashton Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: As hton Idaho. | Date of Burial: 12/10/ 1929

20. Undertaker: Lewis Kiser | Address: Ashton Ida

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68334

PLACE OF DEATH

County of Fremont Registration District No.

City of Marysville Idaho Primary Registration District No.

(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Phoebe Gribble

(a) Residence. No. 131 St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) March 22 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	7	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10 NAME OF FATHER John Reynolds
11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know
12 MAIDEN NAME OF MOTHER Phoebe Ramsay
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Stanley Gribble
(Address) Marysville Idaho

15 Filed 11-22, 1929 C. M. Graham
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
NOV. 22. 1929
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Nov 22 1929, that I last saw her alive on Nov 22, 1929, and that death occurred, on the date stated above, at 10. A M

The CAUSE OF DEATH was as follows:
Acute Bright's disease
Intra cerebral hemorrhage
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. M. Graham M. D.
Nov 23, 1929 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Ashton Idaho	11/25 1929

20. Undertaker Lewis Kiser Address Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68232

PLACE OF DEATH
County of Fremont
City of Marysville

Registration District No. 102
Primary Registration District No. 6
(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Testus Franklin Sprague

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept. 14th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	1	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10 NAME OF FATHER Testus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Anna M. Moultrie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah

14 Informant Ray Sprague.
(Address) Ray Marysville Idaho

15 Filed 11-4, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 4th 1929
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 19 29 to Nov 4, 19 29
that I last saw him alive on Nov 4, 19 29
and that death occurred, on the date stated above, at 11. P M.

The CAUSE OF DEATH* was as follows:
Cancer of Colon
Right Leg

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [signature] M. D.
Nov 5, 19 29 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Ashton Idaho	11/7th 1929

20. Undertaker	Address
Lewis Kiser	Ashton Idaho

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68333

PLACE OF DEATH

County of Fremont
City of Ashton

CERTIFICATE OF DEATH

Registration District No. 102
Primary Registration District No. 6
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Joseph Baker

(a) Residence. No. ..... St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) April 12th 1850

7 AGE Years 79 Months 6 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Famer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10 NAME OF FATHER Thomas Baker
11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know
12 MAIDEN NAME OF MOTHER Dont Know
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Horace Baker
(Address) Ashton Idaho

15 Filed ....., 19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October (Month) 31st (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Oct 31, 1929, that I last saw him alive on Oct 31, 1929, and that death occurred, on the date stated above, at 5. P.M.

The CAUSE OF DEATH* was as follows:
Natural Regurgitation

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature] M. D.
Oct 31, 1929 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Ashton Idaho
Date of Burial 11/3/29

20. Undertaker Lewis Kiser
Address Ashton Idaho

...WITH UNFADING INK—THIS IS A PERMANENT RECORD
...formation should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
...OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC-
...ery important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC[illegible] DEC 13 1929

PLACE OF DEATH

County of FREMONT

City of ASHTON

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 102

Primary Registration District No. 6

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 68334

Local Registrar's No. .....

131

2. FULL NAME WILLIAM HENRY SCHFIELD.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE

4. COLOR OR RACE WHITE

5. Single, Married, Widowed, or Divorced (Write the word) MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of APRIL

6. DATE OF BIRTH (month, day and year) APRIL 18th 1844

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
85	4 4	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work RETIRED FARMER

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ENGLAND

PARENTS

10. NAME OF FATHER JOSEPH SCHOFIELD

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ENGLAND

12. MAIDEN NAME OF MOTHER DONT KNOW

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) DONT KNOW

14. Informant CARL SCHOFILED

(Address) DRUMMOND IDAHO

15. Filed 8-23-, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH AUG. 22th 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Aug 16, 1929, to Aug 22, 1929 that I last saw him alive on Aug 22, 1929 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:
Paralysis of right side and chronic Bright's disease

..... (duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Hitter's

(Signed) [signature], M. D.

Aug 28, 1929 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal HOOPER UTAH — Date of Burial 8/25/29 19

20. Undertaker LEWIS KISER — Address ASHTON IN

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68335

PLACE OF DEATH
County of Ada
City of Emmett
Registration District No. 4
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Georgia Arthur 179

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	white	married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of R. L. Arthur

6. DATE OF BIRTH (month, day and year) Nov 14 - 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	10	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas

PARENTS
10. NAME OF FATHER James Wilson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant F. H. Arthur
(Address) Emmett Ida

15. Filed 9/28, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1927, to Sept 26, 1929
that I last saw her alive on Sept 20-, 1929
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis
Several (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic myocarditis
Several (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? urinary findings.
(Signed) R. N. Cummings, M. D.
9/28, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Brownlee, Ida	9/29 1929
20. Undertaker C. D. Bucknum	Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1929

PLACE OF DEATH

County of Gem

City of Emmett

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68336

Registration District No.

Primary Registration District No. 4

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Erastus B. Preble

(a) Residence. No. St. 131

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Laura Preble

6. DATE OF BIRTH (month, day and year) Oct 6 – 1857

7. AGE Years 72 Months 1 Days 3 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER James Vance Preble

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Melvina O'Rardin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant Nellie P. Reed

(Address) Emmett Idaho

15. Filed 11/10, 1929 J L Raynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on Nov 9, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bright's disease

(duration) several years yrs. mos. ds.

CONTRIBUTORY (Secondary)

unknown (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urin analysis

(Signed) N B Barnes D.O. M. D.

Nov 15, 1929 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Emmett Ida

Date of Burial 11/11 1929

20. Undertaker C D Buckmann

Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68337

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. 6
Primary Registration District No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Donald Dean Shaver

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 23-1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	4	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Emmett
(State or country) Idaho

PARENTS

10. NAME OF FATHER F. E. Shaver
11. BIRTHPLACE OF FATHER (city or town) England
(State or Country)
12. MAIDEN NAME OF MOTHER Inez McKibben
13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Felix E Shaver
(Address) Emmett Ida

15. Filed 11/2, 1929 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Baby was sick several days & Physician called after death probably pneumonia
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) A. L. Ludkins Coroner
11/2, 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Ida	11/3 1929

20. Undertaker C. A. Buckmaster
Address Emmett Idaho

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68338

PLACE OF DEATH
County of Elem
City of Emmett
Registration District No. 6
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Mickey Rosena Johnson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): ~~Oct~~ Nov 28 - 1918

7. AGE: Years 10 | Months 11 | Days 13 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Shelley Idaho

PARENTS

10. NAME OF FATHER: Orville Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ft. Supply Wyoming
12. MAIDEN NAME OF MOTHER: Ruth Kelley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Newton D. Johnson
(Address): Emmett Idaho

15. Filed 12/12, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
accidental death from gun shot wound accidental
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Leslie Adkins Coroner
11/12, 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Ida
Date of Burial: 11/13 1929

20. Undertaker: C. D. Buckenum
Address: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68339

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No.
Primary Registration District No. 4
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Floyd Morganthaler 149

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 30- 1913

7. AGE	Years	Months	Days	If LESS than 1 day,
	15	11	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington

PARENTS

10. NAME OF FATHER Ernest Morganthaler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Sarah Sloyton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Michigan

14. Informant E. Morganthaler
(Address) Emmett Idaho

15. Filed 11/21, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-17-, 1929, to 11-19-, 1929
that I last saw him alive on 11-19-, 1929
and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:
Contusion of brain due to horse accidentally falling with him.
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis? Spinal puncture

(Signed) R. M. Cummings, M. D.
11/21, 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
C. D. Buckmaster	11/22 1929
20. Undertaker C. D. Buckmaster	Address Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68340

PLACE OF DEATH
County of Ada
City of Emmett
Registration District No.
Primary Registration District No. 6
Local Registrar's No.
(No. If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Alexander Phillips 90

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 14 - 1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	9	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Isaac Phillips
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Nancy Hankins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant J. T. McGee
(Address) Boise Idaho

15. Filed 11/19, 1929 J. A. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Found dead in bed
probably heart failure
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Herb Adkins, M.D.
11/19, 1929 (Address) Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Ida	11/19 1929
20. Undertaker C. D. Buckmaster	Address Emmett Idaho

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68341

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME Betty May Rolland

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Infant

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Nov 14 1929

7. AGE — Years: — Months: — Days: 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Emmett Idaho

PARENTS

10. NAME OF FATHER: Albert Rolland
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kansas
12. MAIDEN NAME OF MOTHER: Etta Gray
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Oregon

14. Informant: Albert Rolland
(Address): Emmett Idaho

15. Filed 11/23 1929
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth, 19, to Nov 17, 1929
that I last saw her alive on Nov 17, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Sudden death in bed with
mother. Face & neck congested
cyanosis in appearance
Did not call (duration) Babys yrs. mos. ds.
CONTRIBUTORY (Secondary) not for two days before death when she was apparently normal
Death was probably due to (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Strangulation
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no

(Signed) [illegible], M. D.
11/23, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Ida — Date of Burial: 11/23 1929

20. Undertaker: [illegible] Buckmaster — Address: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1929

PLACE OF DEATH

County of Gem

City of Emmett

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68342

Registration District No. 6

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Adam Frederick Steinbower 98B

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Georgia Steinbower

6. DATE OF BIRTH (month, day and year) Jan 20 – 1854

7. AGE Years 75 Months 9 Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Union Co Ohio

PARENTS

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) not known

14. Informant Georgia Steinbower
(Address) Emmett Idaho

15. Filed 11/6, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 1929, to Nov 4th, 1929 that I last saw him alive on Nov 4th, 1929 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

many yrs (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. L. Reynolds, M. D.

11/6, 1929 (Address) Emmett Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Emmett Ida

Date of Burial Nov. 6 1929

20. Undertaker C D Buckneum

Address Emmett, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68343

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. 6
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

162

2. FULL NAME Benita Ashpaugh

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Gem
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 1 – 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Emmett
(State or country) Idaho

PARENTS

10. NAME OF FATHER Benj. S. F. Ashpaugh
11. BIRTHPLACE OF FATHER (city or town) Wyoming
(State or Country)
12. MAIDEN NAME OF MOTHER Lillian B. Williams
13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Benj. S. F. Ashpaugh
(Address) Emmett, Idaho

15. Filed 11/17, 1929 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 – 1929, to Nov 17, 1929
that I last saw her alive on Nov 19, 1929
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Inadequate feeding
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) No digestion
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. L. Reynolds, M. D.
11/17, 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Emmett, Ida
Date of Burial 11/17 1929

20. Undertaker C. D. Bucknum
Address Emmett Idaho

FORM V. S. No. 5-25 M. 1-29

RECEIVED DEC 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24

Primary Registration District No.

File No. 6834

Registered No. 109

1. PLACE OF DEATH

County of Gooding

City of 4

(No. R.F.D. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary L. Bolte

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 1 (Day) 1863 (Year)

7. AGE: 65 Yrs. 11 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) V. Bolte

(Address) Gooding Idaho

15. Filed 11-30-1929 J H Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 49

Nov (Month) 12- (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1- 1929, to Nov 12- 1929 that I last saw her alive on Nov 8- 1929, and that death occurred on the date stated above, at 3½ A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma began in sub-maxillary gland - infiltrated surrounding tissue (Duration) yrs. 3 mos. ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Cromwell M. D.

19..... (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Gooding Ida — DATE OF BURIAL: 11-14-1929

20. UNDERTAKER: A. E. Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED OCT 25 1930
PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68344

Dr. J.H. Cromwell
Gooding

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

B. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Mary L. Bolte who died at Gooding, Idaho on Nov. 12, 1929
Cause of death given as "Carcinoma."

Information DESIRED in order to complete certificate:

PLEASE STATE THE PRIMARY SEAT OF THE DISEASE.

PLEASE ANSWER BELOW:

Carcinoma - Ligan in sub Maxillary gland - infiltrated surrounding tissues.

FORM V. S. No. 5 RECEIVED DEC 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 6834
Registered No. 110

1. PLACE OF DEATH
County of Gooding
City of Bliss
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred F. Robinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Don't know

6. DATE OF BIRTH: June (Month) 8 (Day) 1873 (Year)

7. AGE: 56 Yrs. 5 Mos. 11 ds.
IF LESS than 1 day: how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber salesman
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): London Eng Land

10. NAME OF FATHER: F Robinson

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: Ellen — —

13. BIRTHPLACE OF MOTHER (State or Country): — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. E. Thompson
(Address) Gooding Ida

15. Filed 11-30 1929 J H Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 19..., to ✓ 19...,
that I last saw h✓ alive on ✓ 19...,
and that death occurred on the date stated above, at ✓ M.
The CAUSE OF DEATH* was as follows:
Unknown
Died suddenly
Probably heart disease
(Duration) ✓ Yrs. ✓ mos. ✓ ds.
Contributory (Secondary)
(Duration) ✓ yrs. ✓ mos. ✓ ds.
(Signed) J H Cromwell - Coroner M. D.
19... (Address) Gooding Co. Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida
DATE OF BURIAL: 11-24 1929

20. UNDERTAKER: A. E. Thompson
ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24

Primary Registration District No.

(No. , St.)

File No. 68346

Registered No. 111

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hilma Andrus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Sep. (Month) 21 (Day) 1907 (Year)

7. AGE: 22 Yrs. 3 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St George Utah

10. NAME OF FATHER: Sheridan Andrus

11. BIRTHPLACE OF FATHER (State or Country): Cottonwood Ut.

12. MAIDEN NAME OF MOTHER: Julia Schlappey

13. BIRTHPLACE OF MOTHER (State or Country): St George Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Walter Prince

(Address) Gooding Ida

15. Filed 11-30- 1929

J H Cromwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 101a

Nov (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-21- 1929, to 11-26- 1929 that I last saw her alive on 11-26- 1929 and that death occurred on the date stated above, at 12:15 PM

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary) Chronic heart disease

(Duration) 15 yrs. mos. ds.

(Signed) J H Cromwell M. D.

11/26 1929 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida

DATE OF BURIAL: 11/30 1929

20. UNDERTAKER: A E Thompson

ADDRESS: Gooding

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1929

PLACE OF DEATH

County of Idaho

City of Grangeville

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 103

Primary Registration District No. 2181

DO NOT WRITE IN THIS SPACE

State File No. 68347

Local Registrar's No. 40

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marion Kramer

(a) Residence. No. Fossile Idaho St. 44
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 68 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Jay Co. Ind.

PARENTS

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (city or town) (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Mrs F. Cummings
(Address) Grangeville Ida.

15. Filed 12-2-, 1929 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 17 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6, 1929, to Nov. 17, 1929 that I last saw him alive on Nov. 17, 1929 and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma Stomach

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Character Emesis

(Signed) B Chipman, M. D.

Nov. 21, 1929 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville Ida — Date of Burial 11-20- 1929

20. Undertaker Hancock Mnf. Co. — Address Grangeville

RECEIVED NOV 26 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68348

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8-1929

2. FULL NAME Peter Hanson Fabricious

50

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of 1902

6. DATE OF BIRTH (month, day and year) [illegible]-5-29

7. AGE Years 27 Months 5 Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Hans M. Fabricious
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.
12. MAIDEN NAME OF MOTHER Ellen Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Hans M Fabricius
(Address) Harrison Idaho

15. Filed 11-8, 1929 H R Barkhurst Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 7- 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6-, 1929, to Nov 7, 1929
that I last saw him alive on Nov 6-, 1929
and that death occurred, on the date stated above, at 11 a m
The CAUSE OF DEATH* was as follows:
Sarcoma of the lungs

(duration) yrs. 3 mos. 2 d

CONTRIBUTORY (Secondary) blue of stomach

(duration) yrs. 4 mos. d

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? clinical & X ray
(Signed) J Wilson Reed M. D.
Nov 7-, 1929 (Address) Harrison I

*State the DISEASE CAUSING DEATH, or in deaths from VIOLEN CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2 whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene
Date of Burial 11-10 1929

20. Undertaker Cassedy Funeral Home
Address C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 26 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68349

PLACE OF DEATH

County of Kootenai
City of Harrison

CERTIFICATE OF DEATH

Registration District No. 126
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 7-1929

2. FULL NAME Patricia Ann Saxon

(a) Residence. No. St. 112
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of V

6 DATE OF BIRTH (month, day and year) Nov. 3-29

7 AGE Years Months Nov. Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) V
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrison

PARENTS
10 NAME OF FATHER W. H. Saxon
11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana
12 MAIDEN NAME OF MOTHER Opal L. Rodgers
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kansas

14 Informant W. H. Saxon
(Address) Harrison Idaho

15 Filed 11-7, 1929 H. R. Bankead. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. (Month) 6- (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1929, to Nov 6-, 1929, that I last saw her alive on Nov 6-, 1929, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:
Gastric Tumor Lage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ✓ yrs. ✓ mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J. Wilson Reed, M. D.
, 19 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Harrison Idaho
Date of Burial: 11-7 1929

20. Undertaker: Cassedy Funeral Home
Address: Harrison

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 26 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6835

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No. 126
Primary Registration District No. 2304

Local Registrar's No. 6 - 1929

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Battista Giovani DeLuca. 129

(a) Residence. No. Harrison Idaho St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 8 mos. 22 ds. How long in U. S., if of foreign birth? 40 yrs. 6 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male,	White	Widower,

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Cristina DeLuca

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	9	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer None.

9. BIRTHPLACE (city or town) Borca Italy
(State or country)

PARENTS

10. NAME OF FATHER
Dominee DeLuca

11. BIRTHPLACE OF FATHER (city or town) Borca Italy
(State or Country)

12. MAIDEN NAME OF MOTHER
Unknown

13. BIRTHPLACE OF MOTHER (city or town) Borca Italy
(State or Country)

14. Informant Louis Dala
(Address) Harrison Idaho

15. Filed Sept. 23 1929
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 23- 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July- 10, 1929, to Sept. 23- 1929
that I last saw him alive on Sept 21- 1929
and that death occurred, on the date stated above, at 1045 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Nephrilis
.....(duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Locomotor Ataxia
.....(duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? V
Did an operation precede death? No Date of V
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J. Wilson Rich, M. D.
Sept 23 1929 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19

20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 26 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68351

PLACE OF DEATH
County of Kootenai
near City of Harrison, Ida.

Registration District No. 126
Primary Registration District No. 2304
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5 - 1929

2. FULL NAME Richard Elbert Stott.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

7/B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE Caucasian.
5. Single, Married, Widowed, or Divorced (write the word) child.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Apr 6th 1921

7. AGE 8 Years | Months 4 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work child.
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Kootenai, Ida.

PARENTS

10. NAME OF FATHER T. A. Stott

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Columbia Co, Wash

12. MAIDEN NAME OF MOTHER Nellie A. Rose

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Walla Walla Co Wash

14. Informant Mrs. T. A. Stott
(Address) Harrison Ida

15. Filed 8-10, 1929 H. R. Bankerd. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 10 (Day) - 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8th, 1929 to Aug 10, 1929.
that I last saw him alive on Aug 10th 1929
and that death occurred, on the date stated above, at 1 45 P. m.
The CAUSE OF DEATH* was as follows:
Tubercular Cerebro-Spinal Meningitis
..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) ✓
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Examination of Spinal Fluid!
(Signed) H. R. Bankerd, M. D.
Aug 10, 1929 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Coeur d'alene Ida. | Date of Burial Aug / 1929.

20. Undertaker Moody | Address Coeur d'alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68352

PLACE OF DEATH
County of Kootenai
City of Spirit Lake

Registration District No. 45
Primary Registration District No.
Local Registrar's No. 5

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert Elwood Lewis.

(a) Residence. No. St. 49
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Vesta Lewis

6. DATE OF BIRTH (month, day and year) 6-3-85

7. AGE 44 Years | Months 1 | Days 9 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hamilton Mo.

PARENTS
10. NAME OF FATHER John W. Lewis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Ida E. Pruett.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Mrs Walter Chrysler
11- N.E. (Address) Brigham City, Utah.

15. Filed July 8, 1929 A C Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to July 12, 1929
that I last saw him alive on July 11, 1929
and that death occurred, on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:
Angina Rectoris
(duration) yrs. 3 mos. 1 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis? Symptoms
(Signed) Nelson Hussey, M. D.
July 12, 1929 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Greenwood Cem. Spirit Lake
Date of Burial: 7-14 1929

20. Undertaker: Cassedy Funeral Home
Address: Spirit Lake

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 14 1929

PLACE OF DEATH

County of Kootenai

City of Spirit Lake.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 45

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68353

Local Registrar's No. 6

1593

2. FULL NAME Robert Kenneth Boviall

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug. 26-1929

7. AGE: Years 0 Months 0 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Spirit Lake Ida.

PARENTS

10. NAME OF FATHER: Wallace Boviall

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Bradford Wis.

12. MAIDEN NAME OF MOTHER: Gladys Bartholomew

13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Wallace Boviall

(Address): Spirit Lake. Ida.

15. Filed Dept 12, 1929 A C Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 12. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to Sept 12, 1929

that I last saw h alive on Sept 12, 1929

and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A C Spooner, M. D.

Dept 12, 1929 (Address) Spirit Lake Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Athol Ida — Date of Burial: 9-13 1929

20. Undertaker: Crossley Funeral Home — Address: Rathdrum

RECEIVED DEC 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68254

PLACE OF DEATH
County of Kootenai
City of Spirit Lake

Registration District No. 45
Primary Registration District No.
Local Registrar's No. 7

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nancy E. Shane

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of L. C. Shane.

6. DATE OF BIRTH (month, day and year) Feb. 28-1843

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86	6	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Wakollage
(State or country) N. Carolinia

PARENTS

10. NAME OF FATHER Bryson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant B. J. Zachary.
(Address) Spirit Lake J.

15. Filed Sept 14, 1929 A. L. Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 13, 1929
that I last saw her alive on Sept 1 1929
and that death occurred, on the date stated above, at 8.00 A m.

The CAUSE OF DEATH* was as follows:

Old age - asthma
1

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Nelson L. Stuley, M. D.
Sept 13, 1929 (Address) Spirit Lake.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal	Date of Burial
Evergreen Cemetery Spirit Lake.	9-14 1929
20. Undertaker	Address
Cassedy Funeral Home	Rathdrum

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68355

PLACE OF DEATH
County of Kootenai
City of Spirit Lake.
Registration District No. 45
Primary Registration District No.
(No.)
Local Registrar's No. 8
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jennie Lockling 90
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Harrison D. Lockling

6. DATE OF BIRTH (month, day and year) May 6-1864

7. AGE	Years	Months	Days	If LESS than 1 day,
	65	5	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER Henry Meade.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~
12. MAIDEN NAME OF MOTHER ~
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ~

14. Informant Walter M. Lockling
(Address) Spirit Lake Idaho

15. Filed Oct 24, 1929 A C Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1929, to Oct 23d, 1929
that I last saw h-er alive on Oct 23d, 1929
and that death occurred, on the date stated above, at 5.27 p m.
The CAUSE OF DEATH* was as follows:

Heart failure
(duration) 15 yrs. 6 mos. 10 ds.
CONTRIBUTORY (Secondary) Pulmonary Tbc
(duration) 19 yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X-Ray plates
(Signed) Nelson J Delacy M. D.
Oct 25, 1929 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Evergreen Cemetery Spirit Lake Idaho	10-25 1929
20. Undertaker Cassidy Funeral Home	Address Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68356

PLACE OF DEATH

County of Kootenai

City of Dalton Gardens
Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 168

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Sherman Campbell. 88a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Addie Campbell

6. DATE OF BIRTH (month, day and year) Jan. 6 1865

7. AGE Years 64 Months 9 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin.

PARENTS

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Catherine Wilson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Dalton Gardens.

(Address) Addie Campbell

15. Filed Nov 29, 1929. H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2, 1929, to Oct 13, 1929

that I last saw him alive on Oct 13, 1929

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis, mitral lesion — myocardial degeneration of long standing.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Alexander Barclay, M. D.

Nov 5, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation, or~~ Removal Sandpoint, Idaho. Date of Burial Nov. 8, 1929

20. Undertaker L. H. Moon Address Sandpoint, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68357

PLACE OF DEATH

County of Kootenai
City of Post Falls
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 107

(No. 107) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eliza E, Christie

(a) Residence. No. R.F.D. # 3 St. Post Falls. Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of N. E. Christie

6. DATE OF BIRTH (month, day and year) June 11, 1863

7. AGE Years	Months	Days	If LESS than 1 day,
66	4	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House-wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not obtainable
12. MAIDEN NAME OF MOTHER Rebecca Sparks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant W. S. Plonski
(Address) Post Falls, Idaho.

15. Filed Nov 29, 1929 N. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 22. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1929, to Oct. 22, 1929
that I last saw her alive on Oct. 21, 1929
and that death occurred, on the date stated above, at 1.00 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
about 2 yrs. mos. ds.
(duration)
CONTRIBUTORY (Secondary) Chronic Gastritis and Duodenitis about 3 yrs. mos. ds.
(duration)

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Frank Ware, M. D.
10/22, 1929 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverside Park Cemetery	10-24 1929
20. Undertaker	**Address**
Smith Funeral Home	Spokane, Wn.

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68358

PLACE OF DEATH

County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 166

(No. Kootenai County Hospital) Rathdrum
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas. E. Termickel 72

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 12 - 1859

7. AGE — Years: 70 | Months: 0 | Days: 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country):

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Mrs. Helen Brown
(Address) Courtesy Matrons - Rathdrum

15. Filed Nov 29, 1929 J. N. J. Stevens Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 9. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 14. 1929, to Novem Br 1929
that I last saw h.. alive on Novbr. 9. 1929
and that death occurred, on the date stated above, at 9.00 p. m.

The CAUSE OF DEATH* was as follows:
Locomotor Ataxia

about 3 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Frank Weng, M. D.
11/9. 1929. (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery - Coeur d'Alene	11/11 1929
20. Undertaker	Address
Cassedy Funeral Home	Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68359

RECEIVED DEC 9 1929

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 3c
Primary Registration District No. 1030
Local Registrar's No. 164

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert James Marsh

(a) Residence. No. 719 - Empire St. 100A
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1926 - 3 - 24

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	7	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur d'Alene. Idaho

PARENTS

10. NAME OF FATHER Earl Marsh
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sprague Wash
12. MAIDEN NAME OF MOTHER Julia Prothy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Moscowville Iowa.

14. Informant Mrs Earl Marsh
(Address) Coeur d'Alene, Ida

15. Filed Dec 9 29, 1929 H. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1929, to Nov 9, 1929, that I last saw h[illegible] alive on Nov. 9 1929 and that death occurred, on the date stated above, at 4 20 a.m.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Harold J Sturgeon M. D.
11-10, 1929 (Address) CDA Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fairmont Cem. Spokane Wn	11-11- 1929
20. Undertaker	**Address**
Cassedy Funeral Home	Coeur d'Alene

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6836

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1650

Local Registrar's No. 163

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jane Grantham

(a) Residence. No. 1211 - Sherman Ave
(Usual place of abode)
Length of residence in city or town where death occurred. 12 yrs. 1 mos. — ds. How long in U. S., if of foreign birth? 37 yrs. 4 mos. 8 ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of A. Grantham

6. DATE OF BIRTH (month, day and year) 1852 - 11 - 23

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	11	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Horsley, England

PARENTS

10. NAME OF FATHER George Glenfield

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Horsley Gloucestershire England

12. MAIDEN NAME OF MOTHER Ann Reynolds

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Stroud Gloucestershire England

14. Informant A Grantham
(Address) 1211 Sherman Ave Coeur d'Alene Idaho

15. Filed 11-29, 1929 W. J. Finnegan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 8th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1929, to Nov. 8, 1929
that I last saw her alive on Nov. 5, 1929
and that death occurred, on the date stated above, at 330 a m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Years Unknown mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No (Signed) J. C. Dwyer, M. D.
What test confirmed diagnosis? Microscopical Examination
Nov. 10, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C'D'Alene	11-10 1929
20. Undertaker	Address
Cassedy Funeral Home	C'D'Alene,

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6836

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 162

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mathilda Dilburg Ely

74A

(a) Residence. No. 468 Lakeside St.
(Usual place of abode)
Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank C Ely

6. DATE OF BIRTH (month, day and year) June 8 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	5	3	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Crop Bonnett Shop
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Dilburg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER [illegible]
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) [illegible]

14. Informant Frank C Ely
(Address) Coeur d' Alene Ida

15. Filed Nov 29, 1929 M. J. Stevens Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH, Nov (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb, 1929, to Nov 11, 1929
that I last saw her alive on Nov 11, 1929
and that death occurred, on the date stated above, at 6.30 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 15 ds.
CONTRIBUTORY (Secondary) Arteria-Sclerosis, Myocarditis
(duration) Not Known yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J C Munro, M. D.
11/12, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	11/13 1929
20. Undertaker	Address
J P Mooney	Coeur d Alene

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68362

PLACE OF DEATH

County of Kootenai

City of near Post Falls

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 161

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188 C

2. FULL NAME Unidentified Man

(a) Residence. No. unknown St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) —

7. AGE Years Months Days If LESS than 1 day, ... hrs. or ..... min.
About 30

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Coroner Office
(Address) Coeur d'Alene, Idaho

15. Filed 12-3, 1929 H. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:
Neck Broken (struck by auto while walking on Yellowstone Trail 2 miles west Post Falls) (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) [signature] Coroner M. D.

Nov 29, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rathdrum Ida
Date of Burial: 12 3 1929

20. Undertaker: Cassedy Funeral Home
Address: C.D.A.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65555

RECEIVED DEC 9 1929

County of Kootenai
City of Coeur d Alene
Registration District No. 50
Primary Registration District No. 1050
Local Registrar's No. 180

(No. Coeur d Alene Hosp)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Paul Schuster

(a) Residence. No. Bay View Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Johanna Schuster

6. DATE OF BIRTH (month, day and year) Nov 11 1872

7. AGE	Years	Months	Days	If LESS than 1 day,
	57	0	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Washington Brick and Lime
(c) Name of employer Bay View Ida

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Richard Schuster
(Address) Bay View Ida.

15. Filed Nov 29, 1929. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12, 1929; to Nov 17, 1929
that I last saw h[illegible] alive on Nov 16, 1929
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:

Myocardial failure.
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Pneumonia Lobar.
(duration) yrs. mos. 12 ds.

18. Where was disease contracted if not at place of death? Bayview Idaho
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Alexander Barclay, M. D.
11-18, 19 (Address) Coeur d'Alene.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Athol Idaho	11/20 1929
20. Undertaker	Address
P B Mooney	Post Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68364

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 159

(No. Coeur d'Alene Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

88 B

2. FULL NAME Peter P. Lang

(a) Residence. No. Harrison Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) unknown

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Aunt 58 — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Harrison Ida.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisc

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Ralph Long
(Address) Harrison Ida

15. Filed Nov 29, 1929 H. J. Sturgee Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to Nov. 17, 1929

that I last saw him alive on Nov. 17, 1929

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harold T. Anderson, M. D.

Nov. 18, 1929 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cemetery

Date of Burial 11/21 1929

20. Undertaker R B Mooney

Address P D A Ida

RECEIVED DEC 9 1929

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68365

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 158

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Carrie Pettis

(a) Residence. No. 517 Sherman St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.

4. COLOR OR RACE W.

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) ~~WIFE~~ of wife Chas. T. Pettis

6. DATE OF BIRTH (month, day and year) 1860-2-3

7. AGE

Years	Months	Days	If LESS than 1 day,
69	9	12	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buffalo. Co. Wis.

PARENTS

10. NAME OF FATHER Edward Green

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Charlotte Vanemaker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wis

14. Informant .....

(Address) Alice E. Clark

15. Filed Nov 29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 15 (Month) Nov. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ‡, 1926, to Nov. 15, 1929

that I last saw her alive on Nov. 14, 1929

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Harold J. Sturges, M. D.

11-18, 1929 (Address) CDA Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cem. CDAlene

Date of Burial: 11-18 1929

20. Undertaker: Cassedy Funeral Home

Address: CDAlene

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68366

Registration District No. 3 c
Primary Registration District No. 1651
Local Registrar's No. 156

PLACE OF DEATH

County of Kootenai
City of Spirit Lake
Camp #43
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hilding Meyers

(a) Residence. No. 174 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 49			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wis.

PARENTS

10. NAME OF FATHER Eric Meyers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Karin Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Axel Meyers
(Address) Spokane Wn

15. Filed 11 29, 1929 H. J. Stringer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on 19
and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:
Suicidal
Cut his throat with a razor.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? none

(Signed) Harold J. Stringer M. D.
Dec. 2, 1929 (Address) Post Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CDAlene	11-22 1929
20. Undertaker	Address
Cossedy Funeral Home	CDAlene

RECEIVED NOV 10 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68366

Dr. H.J. Sturgis
Coeur D'Alene

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

B. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Hilding Meyers who died at Spirit Lake Camp 43 Nov. 17, 1929
Cause of death given as "Suicidal."

Information DESIRED in order to complete certificate:

PLEASE STATE THE MANNER OR MEANS EMPLOYED. (SHOOTING, CUTTING INSTRUMENTS, ETC.)

PLEASE ANSWER BELOW:

Dear Sir
Mr. Meyers cut his throat with a razor. This is all the information we have at present.
Sincerely
Dr. H. J. Sturgis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68367

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Blue Creek.

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 155

2. FULL NAME Robt Joe Keeney

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

162

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1929 - 6 - 24

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
0	4	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Deer Lodge Mont.

PARENTS

10. NAME OF FATHER Joe Keeney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Stevensville Mont.
12. MAIDEN NAME OF MOTHER Carrie Lancaster
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hamilton Mont.

14. Informant Joe Keeney
(Address) Blue Creek

15. Filed Nov 29, 1929 H. J. Sturges
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1929, to Nov. 20, 1929
that I last saw him alive on Dec. 20, 1929
and that death occurred, on the date stated above, at 7 30 P. m.
The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Exam
(Signed) Harold J. Sturges M. D.
Nov. 22, 1929 (Address) CDA Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest-Cem. CDAlene Ida
Date of Burial: 11-22 1929

20. Undertaker: Cassedy Funeral Home
Address: CDAlene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECE[illegible] DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68368

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 154

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lyle Esterbrook

(a) Residence. No. ..... St. 24
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1919-6-8

7. AGE Years 10 Months 5 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur d'Alene Ida

PARENTS
10. NAME OF FATHER Frank B. Esterbrook
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Chicago Ill.
12. MAIDEN NAME OF MOTHER Elsie Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Currie. Minn.

14. Informant Bruce Punches
(Address) Coeur d'Alene Ida

15. Filed Nov 29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 21st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21, 1929, to Nov 21, 1929
that I last saw him alive on Nov 21 1929
and that death occurred, on the date stated above, at 8 10 P m.
The CAUSE OF DEATH* was as follows:
Meningitis (from infected middle ear)
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Otitis Media
(duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? at Home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Symptoms & act
(Signed) F. L. McCauley M. D.
Nov 22, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal C.D. Alene — Date of Burial 11-25 1929

20. Undertaker Cassady Funeral Home — Address C.D. Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68369

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.
(No. Western Hospital Cissandeau Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mettia Nelson 57

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of H. Nelson

6. DATE OF BIRTH (month, day and year) Nov 23 1861

7. AGE: 67 Years, Months 10, Days 26. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway.

PARENTS
10. NAME OF FATHER John Stensrud
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Manit Tidemanson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway.

14. Informant H. Nelson
(Address) Farmington Wash.

15. Filed Oct 20th, 1929 D. J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1929, to Oct 19th, 1929
that I last saw her alive on Oct 19th, 1929
and that death occurred, on the date stated above, at 10:30 a m.
The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) F. C. Gibson, M. D.
Oct 20th, 1929 (Address) Potlatch - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Garfield Wash. Date of Burial: Oct 20 1929

20. Undertaker: E. H. Drum Address: Palouse Wash

RECEIVED NOV 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68370

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.
(No. Western Hospital Association Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles F. Nelson

11a

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE Years About 58 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED Steel Layer
(a) Trade, profession, or particular kind of work Logging R.R.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Morrison & Knudson

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER N. F. Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Victor Nelson
(Address) Wahpeton N. D.

15. Filed Sept 30th, 1929 Dr. Jno. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25th, 1929, to Sept 30, 1929
that I last saw him alive on Sept 30th, 19
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) Jno. Thompson M. D.
Sept 30th, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Palouse Wash. | Date of Burial Oct 18 1929

20. Undertaker E. M. Irwin | Address Palouse Wash.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68371

PLACE OF DEATH
County of Latah
City of Near Potlatch

Registration District No. 65
Primary Registration District No. 2145

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME James Daniel Berry

(a) Residence (Usual place of abode) No. St. (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6. DATE OF BIRTH (month, day and year): June 20 - 1856

7. AGE: Years 73, Months 4, Days 10. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: James B. Berry
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Elenor Grantham
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Mrs Florence Green
(Address) R. 3, Palouse, Wash.

15. Filed Nov 1st, 1929 J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15th, 1929, to Oct 30th, 1929 that I last saw him alive on Oct. 28th, 19 and that death occurred, on the date stated above, at 1:35 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arterio-sclerosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Thompson, M. D.
Nov 1st, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rock Creek Cem. Date of Burial: Nov 1 1929

20. Undertaker: J. M. Irwin Address: Palouse Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68372

PLACE OF DEATH
County of Latah
City of Near Pottatch

Registration District No. 65
Primary Registration District No. 2145
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Ole Soholt

31

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 54 | Months 0 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Yard Man
(b) General nature of industry, business, or establishment in which employed (or employer): Pot latch Lumber Co.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10. NAME OF FATHER: M Soholt
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Elme Oretust
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Mrs Ole Soholt
(Address): Pottatch Idaho

15. Filed Nov 9th, 1929. Dr J.W. Thompson, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov, 1928, to Nov 9th, 1929
that I last saw him alive on Nov 9th 1929
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Phthisis Pulmonalis
(duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) ✓
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J.W. Thompson M. D.
Nov 10th, 1929 (Address) Pottatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pottatch Ida
Date of Burial: Nov 13 1929

20. Undertaker: E M Drum - Palouse Wash.
Address

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68373

Local Registrar's No. 57

PLACE OF DEATH

County of Latah Registration District No. 161

City of Moscow Primary Registration District No. 1011

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Lenard Eugene Peterson

(a) Residence. No. 1024 Harrison St. noa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. 10, 1907

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
21	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Moscow
(State or country) Idaho

PARENTS

10 NAME OF FATHER Conrad Peterson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Sweden

12 MAIDEN NAME OF MOTHER Lena Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Idaho

14 Informant Conrad Peterson

(Address) Moscow, Ida.

15 Filed Nov 30, 1929 W. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Nov. 29, 1929
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1929 to Nov 29, 1929, that I last saw him alive on Nov 29, 1929, and that death occurred, on the date stated above, at 10 30 p. m.

The CAUSE OF DEATH* was as follows:

Acute bronchial pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical only.

(Signed) O. Sandborg, M. D.

Dec. 2, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow	12/2/29 19

20. Undertaker H. R. Short Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68374

PLACE OF DEATH

County of Latah

City of Moscow (rural

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 2141

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 56

2. FULL NAME Ophelia Maguire

(a) Residence. No. Rural St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W.S. Maguire

6 DATE OF BIRTH (month, day and year) June 9, 1867

7 AGE: Years 62 Months 5 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10 NAME OF FATHER E.J. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Anna C. Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Edwin Maguire

(Address) Moscow, Idaho

15 Filed Nov 26, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 26, 1929 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, ~~That~~ I attended deceased from Nov. 21, 1929, to Nov 26, 1929, that I last saw her alive on Nov 26, 1929, and that death occurred, on the date stated above, at 5.45 p m.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) yrs. mos. 3 hrs

CONTRIBUTORY (Secondary) Arteriosclerosis
The interstitial nephritis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical picture

(Signed) [signature], M. D.

11/29, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Moscow

Date of Burial: 11/29/29

20. Undertaker: H. R. Short

Address: Moscow

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68575

PLACE OF DEATH

County of Latah
City of Moscow

CERTIFICATE OF DEATH

Registration District No. 161
Primary Registration District No. 1011
(No.) Local Registrar's No. 55
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Nellie Frazier

(a) Residence. No. St. 129
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Frazier

6 DATE OF BIRTH (month, day and year) Dec. 17, 1880

7 AGE: Years 48, Months 10, Days 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS
10 NAME OF FATHER: C.A. Gummere
11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.
12 MAIDEN NAME OF MOTHER: Elizabeth Huston
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Canada

14 Informant: Frank Frazier
(Address) Moscow, Ida.

15 Filed Nov-11, 1929 W. Lowrithers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 11/ 1929 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1929, to Nov. 10, 1929, that I last saw her alive on Nov. 10, 1929, and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

About (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

About (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Laboratory

(Signed) J. Harry Linhouse, M. D.
11/13, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Moscow
Date of Burial: 11/14/29 19

20. Undertaker: H. R. Short
Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68276

PLACE OF DEATH

County of Latah
City of Moscow

Registration District No. 101
Primary Registration District No. 1011
(No. Gritman Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 54

2. FULL NAME John Thomas Allen

(a) Residence. No. ____ St. ____ (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 12 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Amy Bell Allen

6 DATE OF BIRTH (month, day and year) Oct. 17, 1873

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
56		25	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Chase County
(State or country) Kansas

PARENTS
10 NAME OF FATHER Francis Marion Allen
11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.
12 MAIDEN NAME OF MOTHER Rachel
13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Gladys Allen
(Address) Moscow, Idaho

15 Filed Nov 11, 1929 W. H. Gardner Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 11, 1929
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1929, to Nov 11, 1929
that I last saw him alive on Nov. 10, 1929
and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:
Acute Myocarditis
(duration) ____ yrs. ____ mos. 1 ds.
CONTRIBUTORY (Secondary) Pulmonary Tuberculosis.
(duration) 3 yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical.
(Signed) C. C. Lamborn, M. D.
11/12 '29 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow	11/13/29
20. Undertaker H. R. Short	Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68377

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 53

2. FULL NAME Augustus Bumgarner

(a) Residence. No. Washington St. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ellen Dinora Bumgarner

6 DATE OF BIRTH (month, day and year) July 5, 1853

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
76	4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Waverley Ill.

PARENTS
10 NAME OF FATHER Leander M. Bumgarner
11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Car.
12 MAIDEN NAME OF MOTHER Elizabeth Lowdermilk
13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Car.

14 Informant Mrs. Ellen Bumgarner
(Address) Moscow, Ida.

15 Filed Nov 7, 1929 W. E. Matthews Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov/ 6, 1929
(Month) (Day) 19 (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 18, 1929, to Nov 6, 1929, that I last saw him alive on ..., 19..., and that death occurred, on the date stated above, at 3 30 p m.

The CAUSE OF DEATH* was as follows:
Chronic myocarditis
(duration) ... yrs. 6 mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical symptoms.
(Signed) C. W. Armstrong, M. D.
11/7, 19 29 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow	11/8/29 19
20. Undertaker H. R. Short	Address Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68378

PLACE OF DEATH
County of Latah
City of Kendrick

Registration District No. 63
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Henry P. Hull

(a) Residence. No. St. 127
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Dora M Leslie Hull

6. DATE OF BIRTH (month, day and year) July 18 - 1844

7. AGE Years 85 Months 3 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oxford, N.Y.

PARENTS

10. NAME OF FATHER Harry Hull
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.
12. MAIDEN NAME OF MOTHER Amelia Pendleton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant Mrs. Dora M. Hull
(Address) Kendrick

15. Filed Nov 10, 1929 B. G. Nesbit Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Nov. 8, 1929, that I last saw him alive on Nov. 8, 1929, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows: Acute Gastritis followed with hemorrhage from stomach
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis myocarditis several (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical evidence
(Signed) E. H. Field, M. D.
Nov 8, 1929 (Address) Kendrick

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane Wash. Date of Burial Nov 11 1929

20. Undertaker Brower-Wann Co Address Lewiston Idaho

RECEIVED DEC 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68379

PLACE OF DEATH

County of Latah
City of Juliaetta

CERTIFICATE OF DEATH

Registration District No. 63
Primary Registration District No.
(No.) 74a
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

2. FULL NAME Sara Jane Athen

(a) Residence. No. St. Post Falls Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm.F. Athen

6 DATE OF BIRTH (month, day and year): Unknown

7 AGE: Years: About 72 | Months: | Days: | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Forrestville Ind.

PARENTS
10 NAME OF FATHER: John Wm. Forrest
11 BIRTHPLACE OF FATHER (city or town) (State or country): Harpers Ferry Va.
12 MAIDEN NAME OF MOTHER: Luna Fargo
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Luna Athen Deane
(Address) Juliaetta, Ida

15 Filed Dec 2, 1929 B.P. Nesbit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 30, 1929 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1929, to Nov. 30, 1929, that I last saw her alive on Nov. 30, 1929, and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Wm Hayfield V. M. D.
12/2 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of ~~Burial, Cremation,~~ or Removal: Cour de Alene, Ida
Date of Burial: 12/3 1929

20. Undertaker: H. R. Short
Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 14 1929

PLACE OF DEATH
County of Latah
City of Cameron

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
Registration District No. 63
Primary Registration District No.

DO NOT WRITE IN THIS SPACE
State File No. 68380
Local Registrar's No.

(No.) 74A
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Emelia Wilkey

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Herman Wilkey

6. DATE OF BIRTH (month, day and year) Jan. 10 - 1860

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	10	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) near Milwaukee, Wis
(State or country)

PARENTS

10. NAME OF FATHER Hettenmaier
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Geo. A. Wilkey
(Address) Cameron

15. Filed Nov 22, 1929 B. F. Nesbit Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28, 1929, to Nov. 21, 1929, that I last saw her alive on Nov 18, 1929, and that death occurred, on the date stated above, at 12:30 p. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Previous hemorrhage
Arteriosclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? clinical symptoms

(Signed) E. H. Field M. D.
Nov. 21, 1929 (Address) Kendrick

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cameron	Nov 23 1929

20. Undertaker	Address
J. J. Packard	Moscow

RECEIVED DEC 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68381

PLACE OF DEATH

County of Latah
City of Deary
Registration District No. 64
Primary Registration District No. 2144
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Belle Brannon

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of John Brannon

6. DATE OF BIRTH (month, day and year) June 12-1864

7. AGE	Years	Months	Days	If LESS than 1 day,
	65	5	15	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

10. NAME OF FATHER H. Lee

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway

12. MAIDEN NAME OF MOTHER Mary Lee

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant
(Address)

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7, 1929, to Dec 7, 1929
that I last saw her alive on Dec 7, 1929
and that death occurred, on the date stated above, at 5 10 A m.
The CAUSE OF DEATH* was as follows:
Cerebral Embolism
instantaneous (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Walter R. Wereley M. D.
Dec 8, 1929 (Address) Bovill Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Norwegian cem Deary	Dec 10 1929
20. Undertaker	Address
John J. Pickerd	Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68382

PLACE OF DEATH
County of Lemhi
City of Salmon City

Registration District No. 47
Primary Registration District No. 2116
Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Winfield Allen Clark

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	60	5	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Livestock Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unity, Main

PARENTS

10. NAME OF FATHER: Do not know
11. BIRTHPLACE OF FATHER (city or town) (State or Country): " " "
12. MAIDEN NAME OF MOTHER: " " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " " "

14. Informant: George Wallace Clark
(Address) 216 North 26 St. Billings, Montana

15. Filed Oct 29, 1929 Chas Kellam Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 28th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25, 1929, to Oct 25, 1929
that I last saw him alive on Oct 28th, 1929
and that death occurred, on the date stated above, at 6-45 m.
The CAUSE OF DEATH* was as follows:

Empyema of Brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture base of skull - thrown from horse, run over & supposedly
Pitched on head (duration) yrs. 3 hours mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F.S. Wright, M. D.
Oct 29, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Dillon Mont — Date of Burial 19
20. Undertaker: W M C Dodds — Address: Salmon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 23 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68382

Dr. F.S. Wright
Salmon

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Winfield Allen Clark who died Oct. 28, 1929 at Salmon City, Idaho
Cause of death given as "Compression of Brain. Fracture base of skull."

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH? IF AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Please

This man was struck by a horse & run over & supposedly kicked in head,

F.S. Wright-MD
Salmon 10/21/30.

RECEIVED NOV 21 1929

PLACE OF DEATH

County of Lemhi

City of Salmon

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68383

Registration District No. 4

Primary Registration District No. 2116

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baylis W. Hawkins

(a) Residence. No. Salmon St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): March 17th 1891

7. AGE: 38 Years — Months: 6 Days: 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Garage man Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Frank Bellamy

9. BIRTHPLACE (city or town) (State or country): Leadville Colo

PARENTS

10. NAME OF FATHER: Jos Hawkins

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Ellen Baylis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wilsonville Ohio

14. Informant: Mrs Ellen Hawkins
(Address) Salmon

15. Filed 11/10, 1929 Lit Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct ~~15th~~ 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16th 1929 to Aug 26 1929 Oct 13 1929 Oct 15 1929 that I last saw him alive on Oct 15th, 1929 and that death occurred, on the date stated above at 6-30 P m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 1-1929

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Bratton, M. D.

Oct. 17th, 1929 (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery — Date of Burial: 10-17th 1929

20. Undertaker: Mrs C. Hoebler — Address: Salmon Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68384

PLACE OF DEATH
County of Lemhi
City of Carmen

Registration District No. 71
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Nels Fredrick Carlson 90
(a) Residence. No. Leadore Idaho St. Carmen
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? 48 yrs. 3 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara J Carlson
6. DATE OF BIRTH (month, day and year): May-19th/1855
7. AGE: Years 74, Months 5, Days 6. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....
9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10. NAME OF FATHER: Carl Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: H. T. Carlson
(Address): Carmen Ida

15. Filed Nov 10, 1929 Cho Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct-25" 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Oct 25, 1929
that I last saw him alive on Oct 20, 1929
and that death occurred, on the date stated above, at 12-10 P m.
The CAUSE OF DEATH* was as follows:
Aortic Stenosis
(duration) ..... yrs. 5 mos. ..... ds.
CONTRIBUTORY (Secondary): Influenza
(duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) T. B. Wright, M. D.
Nov 2, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery — Date of Burial: 10-27" 1929
20. Undertaker: Wm C Doebler — Address: Salmon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68385

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME Sam Lehman

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Alice Lehman

6. DATE OF BIRTH (month, day and year) Feb. 4, 1853

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
76	9	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer, Retired
(c) Name of employer

9. BIRTHPLACE (city or town) Defiance
(State or country) Ohio

PARENTS

10. NAME OF FATHER Jacob Lehman
11. BIRTHPLACE OF FATHER (city or town) Germany
(State or Country)
12. MAIDEN NAME OF MOTHER Phebe Freece
13. BIRTHPLACE OF MOTHER (city or town) Germany
(State or Country)

14. Informant Mrs V. E. Niswander
(Address) Winchester, Idaho

15. Filed Nov 25, 1929 R. E. Dunlap Registrar
per H. W. Shryock

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18, 1929, to Nov 23, 1929
that I last saw him alive on Nov 23, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Pneumonia & Respiratory Tumor
Following Centrifugal Hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) John F. Gist M. D.
11/25, 1929 (Address) Winchester Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Winchester
Date of Burial 11/25 1929

20. Undertaker Clyde Clouis
Address Daigmont Ill.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68386

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Lemon Virgil Thomason

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

201

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 19 1913

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
16	7	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) School boy
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewis County Idaho

PARENTS

10. NAME OF FATHER Lewis M. Thomason
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Arkansas
12. MAIDEN NAME OF MOTHER Hannah E. Skaggs
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Texas

14. Informant Vance L. Thomason
(Address) Craigmont Ida

15. Filed Nov 12, 1929 R. E. Dunlap Registrar
Per H. W. Shryock

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (11) 19 — 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9, 1929, to Nov 11, 1929
that I last saw him alive on Nov 11, 1929
and that death occurred, on the date stated above, at 12 noon
The CAUSE OF DEATH* was as follows: Brown Fracture of Skull thrown from horse
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) John F. Gist, M. D.
Nov 10, 1929 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cuisinière Ida
Date of Burial: Nov 12 1929

20. Undertaker: Brown-Wurm Co
Address: Lewiston Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
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NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68386

Dr. J.F. Gist
Winchester

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

B. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Vernon Virgil Thomason who died at Winchester, Idaho on Nov. 11, 1929
Cause of death given as "Basal Fracture of Skull."

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Was out riding horseback and as the horse returned without the rider and investigation disclosed that the lad had apparently been thrown from the horse and was picked up unconscious a short distance from his home.

RECEIVED NOV 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68387

PLACE OF DEATH

County of Lincoln
City of Dietrich

Registration District No. 16
Primary Registration District No. 2016
Local Registrar's No. 16

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

140

2. FULL NAME Rose Savage

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: M C Savage

6. DATE OF BIRTH (month, day and year): Feb 14 1892

7. AGE: Years 37 | Months 8 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Elba Idaho

PARENTS

10. NAME OF FATHER: B C Barker
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Brigham Utah
12. MAIDEN NAME OF MOTHER: Holland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: M C Savage
(Address): Dietrich Ida

15. Filed Nov 9, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9 9 AM, 1929, to Nov 9 11.30 AM, 1929
that I last saw her alive on Nov 9, 1929
and that death occurred, on the date stated above, at 11.30 A m.
The CAUSE OF DEATH* was as follows:
Hemorrhage
Placenta Previa
..... (duration) ..... yrs. ..... mos. 12 hrs. ds.
CONTRIBUTORY (Secondary): Aortic Regurgitation
..... (duration) 1 yrs. 1 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Poly Exam
(Signed) F. E. Barrett, M. D.
Nov 9, 1929 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Elba Idaho | Date of Burial: Nov 11 1929

20. Undertaker: C E Hickok | Address: Shoshone Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68388

PLACE OF DEATH

County of Lincoln
City of Richfield

Registration District No. 16
Primary Registration District No. 2016
Local Registrar's No. 17
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Geo Wilmoth

90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Elizabeth Wilmoth

6. DATE OF BIRTH (month, day and year) June 7 1849

7. AGE Years 80 Months 5 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10. NAME OF FATHER Eliga Wilmoth
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Mary Jane Hall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mary Elizabeth Wilmoth
(Address) Richfield

15. Filed Nov 23, 1929 J L Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I did not attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on Dead when I arrived, 19.....
and that death occurred, on the date stated above, at 7 30 a.m.
The CAUSE OF DEATH* was as follows:

Heart Failure

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? History
(Signed) F. E. Barrett, M. D.
Nov 12, 1929 (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone Idaho
Date of Burial: Nov 14 1929

20. Undertaker: C E Hickok
Address: Shoshone Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 26 REVISED DEC 9 1928

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68289

Local Registrar's No. 96

1. PLACE OF DEATH

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Henry Flamm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Aug. 12 1867
(Month) (Day) (Year)

7. AGE: 62 Yrs. 1 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): Self

9. BIRTHPLACE (State or Country): Toronto Canada

10. NAME OF Father: Caleb W. Flamm

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Catherine Bowen

13. BIRTHPLACE OF MOTHER (State or Country): Toronto Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Alice Flamm

(Address) Rexburg RFD. # 1

15. Filed 11/4 1929 J Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Oct~~ Nov 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1929, to Oct 1929, that I last saw h/M. alive on Dec 25 1929, and that death occurred on the date stated above, at 8 45 P.M.

The CAUSE OF DEATH* was as follows:

Cardio-vascular renal disease

(Duration) 1 yrs. 6 mos. ..... ds.

Contributory (Secondary) Uremic Chronic parenchymatous

(Duration) ..... yrs. 6 mos. ..... ds.

11/ (Signed) Lorin A Koch M. D.

1/4 1929 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg Cemetery — DATE OF BURIAL: 11/6 1929

20. UNDERTAKER: A B Eckersell — ADDRESS: Ryberg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED DEC 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 6899

Local Registrar's No. 76

1. PLACE OF DEATH

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donna M Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Child

6. DATE OF BIRTH: Feb. 23 1926 (Month) (Day) (Year)

7. AGE: 3 Yrs. 8 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rexburg Idaho

10. NAME OF Father: Joseph P Evans

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Martha Worlton

13. BIRTHPLACE OF MOTHER (State or Country): Salem Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Martha Evans
(Address) Rexburg Idaho

15. Filed 11/9 1929 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 - 1929, to Nov 7 1929, that I last saw her alive on Nov 6th 1929, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Peritonitis
diffuse, septic.

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) Unknown (over)

(Duration) ..... yrs. ..... mos. ..... ds.

11/9 1929 (Signed) Lorin A Rich M. D.
(Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar City Cemetery — DATE OF BURIAL: 11/9/29 19.....

20. UNDERTAKER: A B Eckersell — ADDRESS

FORM V. S. No. 5-25 M. 1-19

RECEIVED DEC 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68291

Local Registrar's No. 77

1. PLACE OF DEATH

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen M Spaulding

3)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Married~~ Widow (Write the word)

6. DATE OF BIRTH: Nov. (Month) 14 (Day) 1879 (Year)

7. AGE: 49 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Logan Utah

10. NAME OF Father: George McCullock

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Cathrine Smith

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thelma Spaulding
(Address) Rexburg Idaho

15. Filed 11/10 1929 J Rysonny Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1929, to Nov 8 1929 that I last saw her alive on Nov. 8 1929 and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 4 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. Sutherland M. D.

11/10 1929 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton Cemetery

DATE OF BURIAL: 11/12/29 19.....

20. UNDERTAKER: A B Eckersell

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 9 1929

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68209

Local Registrar's No. 98

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Madison

City of Hibbard

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George S. Statham

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Divorced

6. DATE OF BIRTH Nov. (Month) 10 (Day) 1887 (Year)

7. AGE 42 Yrs. 8 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father George H. Statham

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Sarah Ann Rokeny

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Statham

(Address) Thornton

15. Filed 11/12 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1929, to Nov 9 1929, that I last saw h... alive on Nov 9 1929, and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Coronary Thrombosis)

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

11/12 1929 (Address) Parkdale Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rexburg Cemetery — **DATE OF BURIAL** 11/12 1929

20. UNDERTAKER A B Eckersell — **ADDRESS**

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Madison

City of Thornton

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

State File No. 68393

Local Registrar's No. 79

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hans Charles Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH: June (Month) 2 (Day) 1863 (Year)

7. AGE: 66 Yrs. 5 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF Father: James Jence Hansen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Elena Iverson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Hansen

(Address) Rexburg Idaho

15. Filed 11/12 1929 J. Reyonrg Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1 1929, to Nov. 10 1929, that I last saw him alive on Nov 10, 1929, and that death occurred on the date stated above, at 2300 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma Sigmoid colon

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. B. Rigby M. D.

11/12 1929 (Address) Rexburg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton

DATE OF BURIAL: 11/13 1929

20. UNDERTAKER: A B Eckersell

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68394

PLACE OF DEATH

County of Madison
City of Hibbard

Registration District No. 100
Primary Registration District No. 2178
(No.) 164
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 80

2. FULL NAME Karl Keppner

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower
5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Christene Keppner
6. DATE OF BIRTH (month, day and year) 1831
7. AGE: Years 93 Months 3 Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Germany
PARENTS
10. NAME OF FATHER Henry Keppner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Elizabeth Dorley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany
14. Informant L. A. Keppner
(Address) Rexburg #3
15. Filed 11/18, 1929 J. Rysong Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 14 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June, 1928, to June 2, 1929
that I last saw him alive on June 2, 1929
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows: Senility.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Age
(Signed) Lorin E. Rich M. D.
11/18, 1929 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rexburg Ida. Date of Burial: Nov. 18 1929.
20. Undertaker: Vern J. Keller Address: Rexburg

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68295

Local Registrar's No. 81

Registration District No. 100

Primary Registration District No. 2178

1. PLACE OF DEATH
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number. 74A

2. FULL NAME Annie M Cox

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6. DATE OF BIRTH: Nov 20th 1858 (Month) (Day) (Year)

7. AGE: 69 Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF Father: John M Brown

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Annie Lugenpunkin

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 11/18 1929 J Rymer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16th 1929, to Nov 18 1929, that I last saw her alive on Nov 18 1929, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) Cardio-vascular renal disease

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Louis A Reck M. D.

11/18 1929 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19.....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED DEC 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68396

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 82

1. PLACE OF DEATH

County of Madison

City of Rexburg

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Rowells 124

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Infant

6. DATE OF BIRTH: Nov (Month) 21 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 15 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sugar City Idaho

10. NAME OF Father: William Lester Rowells

11. BIRTHPLACE OF FATHER (State or Country): Parker Idaho

12. MAIDEN NAME OF MOTHER: Edna Allgood

13. BIRTHPLACE OF MOTHER (State or Country): Milford, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. L. Rowells

(Address) Sugar City Idaho

15. Filed 11/21 1929

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1929, to Nov 20 1929, that I last saw her alive on Nov 21 1929, and that death occurred on the date stated above, at 6:09 M.

The CAUSE OF DEATH* was as follows:

Sarcoma Liver

(Large firm foetal tumor

extending from fourth

rib to (Duration) above Bp. (sub-) yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Rigby M. D.

(Address) Rexburg

11/21 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City Cemetary — DATE OF BURIAL: 11/24 1929

20. UNDERTAKER: A. E. Eskelsen — ADDRESS: .....

FORM V.S. No. 5-25 M. 1-19 RECEIVED DEC 9 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

State File No. 68397

Local Registrar's No. 83

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Catherine B Clucas

44

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH: July (Month) 16 (Day) 1860 (Year)

7. AGE: 69 Yrs. 4 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Heights Town New Jersey

10. NAME OF Father Samuel H Gravatt

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Catherine Ballard

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Clucas
(Address) Rexburg Idaho

15. Filed 11/28 1929 J Lyons Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1929, to Nov 27 1929, that I last saw her alive on Nov 26 1929, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(Duration) 10 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carley Nelson M. D.

Nov 28 1929 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg Cemetery

DATE OF BURIAL: 11/30 1929

20. UNDERTAKER: A B Eckersell

ADDRESS: Rexburg Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68398

PLACE OF DEATH

County of Madison
City of Rexburg
Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 84

(No. 120)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elliott Coterell

(a) Residence. No. Ashton, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mary M. Coterell

6. DATE OF BIRTH (month, day and year) March 16th, 1889

7. AGE	Years	Months	Days	If LESS than 1 day,
	40	3	14	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9. BIRTHPLACE (city or town) Utah.
(State or country)

PARENTS

10. NAME OF FATHER Joseph Coterell
11. BIRTHPLACE OF FATHER (city or town) Utah.
(State or Country)
12. MAIDEN NAME OF MOTHER Sarah Ann Bowman
13. BIRTHPLACE OF MOTHER (city or town) Utah.
(State or Country)

14. Informant Mrs Mary M. Coterell
(Address) Ashto, Idaho.

15. Filed 12/1, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 1 — 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1929, to Dec. 1, 1929
that I last saw him alive on Dec. 1, 1929
and that death occurred, on the date stated above, at 1245 a. m.
The CAUSE OF DEATH* was as follows:
Peritonitis,
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Pus appendicis.
(duration) yrs. mos. 11 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Nov. 22-29
Was there an autopsy? no
What test confirmed diagnosis? Pus + Swelling.
(Signed) S. M. Kelly, M. D.
Dec. 1, 1929 (Address) St Anthony Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ashton, Idaho.	Dec. 4th, 1929

20. Undertaker W. A. Hansen Address St. Anthony, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Madison

City of Sunny Dell

If death occurs away from usual residence, give facts called for under special information.

REC DEC 9 1929

CERTIFICATE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68399

Local Registrar's No. 85

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marvin Wilcox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: July (Month) 8 (Day) 1892 (Year)

7. AGE: 37 Yrs. 4 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sunny Dell Idaho

10. NAME OF Father: David Wilcox

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Melinda Cook

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David Wilcox

(Address) Thornton R F D #1

15. Filed 12/2 1929 J. Reyonrg Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1926, to June 1929, that I last saw him alive on June 15 1929, and that death occurred on the date stated above, at 9 am M.

The CAUSE OF DEATH* was as follows:

Epilepsy.

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) Chronic Epilepsy

(Duration) 10 yrs. ..... mos. ..... ds.

12/2 (Signed) Rosie F. Rich M. D.

1929 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds. none

Where was disease contracted if not at place of death? Place of death

Former or usual residence Sunny Dell Idaho.

19. PLACE OF BURIAL OR REMOVAL: Archer Cemetery

DATE OF BURIAL: 12/3 1929

20. UNDERTAKER: A B Eckersell

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68400

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 86

(No.) 74a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bertha Lamoreaue Montague.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	2	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Farmington Utah.

PARENTS

10. NAME OF FATHER David B. Lamoreaue
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada.
12. MAIDEN NAME OF MOTHER Nancy Orrell.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant L. A. Montague.
(Address) Rexburg Idaho.

15. Filed 12/2, 1929 [illegible] Wyoming Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27, 1929, to Dec. 2, 1929
that I last saw h[illegible] alive on Dec. 2, 1929
and that death occurred, on the date stated above, at 12:52 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) [illegible] Sutherland, M. D.
12-2, 1929 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho.	Dec. 4 1929
20. Undertaker	Address
Vern J. Keller	Rexburg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC'D DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68401

PLACE OF DEATH
County of Minidoka
City of Heyburn
Registration District No. 19
Primary Registration District No. 2015
Local Registrar's No. 58
(No. 1010)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Beverly Heiner

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 24 1929

7. AGE — Years | Months: 1 | Days: 19 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Heyburn
(State or country) Ida

PARENTS

10. NAME OF FATHER Elmer S Heiner
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Leah Moon
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Mexico

14. Informant Elmer S Heiner
(Address) Heyburn Ida

15. Filed Nov. 17, 1929. E. W. Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1929, to Nov. 12, 1929
that I last saw h[illegible] alive on Nov. 12, 1929
and that death occurred, on the date stated above, at 12 p m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? By symptoms
(Signed) Dan Johnson, M. D.
Nov. 18, 1929 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Heyburn Ida — Date of Burial: Nov. 13 1929

20. Undertaker: D. E. JOHNSON — Address: Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68402

PLACE OF DEATH
County of Minidoka
City of Heyburn

Registration District No. 14
Primary Registration District No. 2013
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 57

100a

2. FULL NAME Barbara Heiner

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 24, 1929

7. AGE Years Months 1 Days 9 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Heyburn Ida.

PARENTS

10. NAME OF FATHER Elmer S Heiner

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Leah Moon

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico

14. Informant E. S. Heiner
(Address) Heyburn Ida.

15. Filed Nov 7, 1929 E H Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1929, to Nov 3, 1929
that I last saw her alive on Nov 3, 1929
and that death occurred, on the date stated above, at 1 A. m.
The CAUSE OF DEATH* was as follows:
Bronchi Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinic
(Signed) Hugh E Dean, M. D.
, 19 (Address) Burley Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Heyburn Ida. Date of Burial Nov. 3 1929

20. Undertaker W. E. Johnson Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

E

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68403

PLACE OF DEATH
County of Minidoka
City of Minidoka
Registration District No. 19
Primary Registration District No. 2015
Local Registrar's No. 56
(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rosella May Swengel

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of W. E. Swengel

6 DATE OF BIRTH (month, day and year) July 7 1875

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10 NAME OF FATHER John Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Julia A. McAfee

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Julia Swengel
(Address) Minidoka Idaho

15 Filed 11-11, 1929 E. B. Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 11 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1929, to Sept. 11, 1929, that I last saw her alive on Sept. 11, 1929, and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:
Chronic valvular disease
(duration) 5 yrs. ..... mos. ..... ds.
CONTRIBUTORY Rheumatism
(Secondary)
(duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) E. B. Elmore M. D.
11-11, 1929 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Rupert Cemetery	Sept 15 1929
20. Undertaker W. G. Goodman	Address Rupert Idaho

RECEIVED DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68404

PLACE OF DEATH

County of Minidoka
City of Rupert
Registration District No. 19
Primary Registration District No. 2019 25
Local Registrar's No. 55
(No. 1012)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gustave Quanstrom

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day,
59	9	6	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED Faemer
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Carl Quanstrom

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Maria Pearson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Charles Quanstrom
(Address) Hyrum Utah

15. Filed Nov. 19, 1929 Ell Ehmen
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 16 (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1929, to Nov. 16, 1929
that I last saw him alive on ....., 19....
and that death occurred, on the date stated above, at 11 20 P. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Chronic Valvular disease
..... (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Ell Ehmen M. D.
Nov. 19, 1929 (Address) Rupert. Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hyrum Utah	19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68406

PLACE OF DEATH

County of Minidoka

City of Minidoka

Registration District No. 19

Primary Registration District No. 2015

Local Registrar's No. 60

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vern W ~~Speer~~ Speers

90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): May 24th 1881

7. AGE: Years 48, Months 5, Days 9. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED: Railroad Employe

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS

10. NAME OF FATHER: William Speers

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Maria Smith

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New York

14. Informant: Irene Benson
(Address) Minidoka Idaho

15. Filed Nov. 21, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2nd, 1929, to Nov 3rd 29 19..
that I last saw him alive on Nov 2nd 29 19..
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

arteriosclerosis

several (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Layne H. Renogy, M. D.

11-21-1929, 19.. (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rupert Cemetry — Date of Burial: Nov 6th 1929

20. Undertaker: W A Goodman — Address: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68107

PLACE OF DEATH

County of Minedoka

City of Rupert

Registration District No. 19

Primary Registration District No. 2015

Local Registrar's No. 59

(No. 90)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nellie Fairchild

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph M Fairchild

6. DATE OF BIRTH (month, day and year) Dec 5 1907

7. AGE	Years	Months	Days	If LESS than 1 day,
	21	11	23	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER John A Jolley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Liddia A Johnson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant J.M.Fairchild

(Address) Burley Ida

15. Filed Dec. 2, 1929 E. H. Chance Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2- 1929, to Nov 28- 1929

that I last saw her alive on Nov 28 12.05 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Toxic Goitre

(duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hiram E. Chance, M. D.

Nov 28, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Oakley R F D #1	Nov. 30 1929
20. Undertaker D. E. Johnson	Address Burley

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68408

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Jonathan Alonzo Phillips

(a) Residence. No. ... St. ... Billings Montana
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 12 - 1863

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	—	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dora.

PARENTS

10. NAME OF FATHER Van Phillips
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant L D Phillips
(Address) Spokane East 2501 - 1st Ave

15. Filed Dec 1, 1929. Emma E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-30-29, 19..., to 11-1-29, 19...
that I last saw h— alive on 11-1-29, 19...
and that death occurred, on the date stated above, at 7 a. m.
The CAUSE OF DEATH* was as follows:

Fracture at base Skull
Auto Accident

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs & symptoms

(Signed) N. Royal M.D. M. D.
11-1-29, 19... (Address) Lewiston Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wash	19

20. Undertaker	Address
Dassas Und Co	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 1 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

H. Rouse
Lewiston, Idaho

68408

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

E. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:

Jonathan alonzo phillips who died Nov. 1, 1929.
Cause of death given as"Fracture at base of skull."

Information DESIRED in order to complete certificate.

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH? - Auto accident.

PLEASE ANSWER BELOW

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6 S 1 1 6

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Emary Hindman

(a) Residence. No. Grangeville Ida St. Grangeville Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 25 - 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Mason Hindman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Elizabeth Taylor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Sisters of St Joseph
(Address)

15. Filed Dec 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 4th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2nd, 1929, to Nov 4th, 1929
that I last saw him alive on Nov 4th, 1929
and that death occurred, on the date stated above, at 11:30 a.m.
The CAUSE OF DEATH* was as follows:

Tapeworm
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Strangulated Hernea
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? Grangeville Ida
Did an operation precede death? Yes Date of Nov 2nd 29
Was there an autopsy? No
What test confirmed diagnosis? Operation & Symptoms
(Signed) O C Casseus M. D.
Nov 4th, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville	11/4 1929
20. Undertaker Casseus Lewiston	Address Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68410

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

107

2. FULL NAME Dorothy Brill
(a) Residence. No. 15th Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb 8 - 1917

7. AGE: Years 12, Months 8, Days 28. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lewiston Idaho

PARENTS

10. NAME OF FATHER: B. C. Brill
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Daisy Stevens
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Lewiston, Idaho.

14. Informant: B. T. Weaver
(Address): Lewiston Idaho.

15. Filed Dec 1, 1929. Susan E Bruce, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 6th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-5-29, 19__, to 11-6-29, 19__
that I last saw her alive on 11-6-29, 19__
and that death occurred, on the date stated above, at 6:30 p.m.
The CAUSE OF DEATH* was as follows:
Edema of lungs.
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary): Influenza - Difficult breathing
Possible Diphtheria - Culture Negative (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 11-5-29
Was there an autopsy? No
What test confirmed diagnosis? Signs & symptoms
(Signed) E. L. White, M. D.
11/6, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 11/7 1929

20. Undertaker: Brower-Wann Co. Address: Lewiston, Idaho.

RECEIVED OCT 28 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68410

Dr. E.L. White
Lewiston

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

B. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Dorothy Brill who died at Lewiston, Idaho on Nov. 6, 1929
Cause of death given as "Edema of lungs. Influenza."

Information DESIRED in order to complete certificate:

PLEASE GIVE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Difficult breathing Possible Diphtheria but Culture was negative.

E. L. White

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68411

PLACE OF DEATH RECEIVED DEC 03 1929

County of Nez-Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

(No. St. Josephs Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Edward Burns

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m

4. COLOR OR RACE w.

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bachelor.

6. DATE OF BIRTH (month, day and year) Oct 31 - 1848

7. AGE Years 81 Months 0 Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10. NAME OF FATHER Edw Burns Sr

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Sisters of St Joseph
(Address)

15. Filed Dec 1, 1929. Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 6 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929, to Nov. 6, 1929

that I last saw him alive on Nov. 6, 1929

and that death occurred, on the date stated above, at 11 30 p. m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis.

(duration) 5 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs.

(Signed) William P. H. Habel, M. D.

, 19 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Cemetery

Date of Burial 11/9 1929

20. Undertaker Vassar Mortuary

Address Lewiston.

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68412

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 95
Primary Registration District No. 1009
(No. ....)
Local Registrar's No. ....
(If death occurred in a hospital or institution, give its name instead of street and number.)

1002

2. FULL NAME W. D. Blair

(a) Residence. No. Lewiston Orchards St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 18 1856

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	6	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER James Blair
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Emaline Jasper
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant J. F. Blair
(Address) Lewiston Orchards

15. Filed Dec 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Nov 6, 1929
that I last saw him alive on Nov 5, 1929
and that death occurred, on the date stated above, at 5:00 a. m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W O Clark, M. D.
Nov 6, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Vassar Co. Deer Pk Wash	19

20. Undertaker	Address
Vassars Mortuary	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68413

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.

PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Clyne
(a) Residence. No. 811 - 7th Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1845

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	-	-	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ontario

PARENTS
10. NAME OF FATHER Wm Clyne
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Maria Morris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant M. J. McNichols
(Address) 811 - 17th ave Lewiston

15. Filed Dec 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6, 1929, to Nov 6, 1929
that I last saw him alive on Nov 6, 1929
and that death occurred, on the date stated above, at 1 A.m.
The CAUSE OF DEATH* was as follows:
Senility
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) R. T. Scott M. D.
Nov 15, 1929 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston — Date of Burial: Nov 9th 1929
20. Undertaker: Sassas Mortuary — Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

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MARGIN RESERVED FOR BINDING

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68414

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lillian Weaver 90

(a) Residence. No. 716 - 6th Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of W J Weaver

6. DATE OF BIRTH (month, day and year) Aug 28th 1883

7. AGE	Years	Months	Days	If LESS than 1 day,
	46	3	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Asotin
(State or country) Washington

PARENTS

10. NAME OF FATHER D. B. Harris
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Jackson County, Illinois
12. MAIDEN NAME OF MOTHER Rachel M. Luttrell
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Polk Co., Missouri

14. Informant W. J. Weaver
(Address) Lewiston, Idaho

15. Filed Nov 9, 1929 Emma E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 8th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25, 1929, to Nov 8th, 1929
that I last saw h deceased alive on Nov 5th, 1929
and that death occurred, on the date stated above, at 8:20 a.m.
The CAUSE OF DEATH* was as follows:

Heart block
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Don't know
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Autopsy Terry Nurses
(Signed) O. L. Terrell, M. D.
11/8, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	11-10 1929
20. Undertaker	Address
A. R. Moreland	Clarkston Wn

Clark

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68415

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

100a

2. FULL NAME Robert White

(a) Residence. No. 406 - 5th Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 15 1849

7. AGE Years 80 Months — Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) New Haven Ohio
(State or country)

PARENTS

10. NAME OF FATHER White
11. BIRTHPLACE OF FATHER (city or town) Venice Ohio
(State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) Venice Ohio
(State or Country)

14. Informant C. J. White
(Address) Lewiston Idaho

15. Filed Dec 1, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12, 1929, to Nov 13, 1929
that I last saw him alive on Nov 13, 1929
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical signs
(Signed) W O Clark, M. D.
11/15, 1929 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Cincinnati Ohio
Date of Burial 19

20. Undertaker Brown Warren Co
Address Lewiston Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 13 1929

PLACE OF DEATH

County of Nezperce

City of Lewiston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

(No. St Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 68416

Local Registrar's No.

162

2. FULL NAME Carl Sennett

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 12, 1929

7. AGE Years	Months	Days	If LESS than 1 day,
		1	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston, Ida.

PARENTS

10. NAME OF FATHER E.D. Sennett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Newport N.H.

12. MAIDEN NAME OF MOTHER Beatrice Peterson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Troy, Ida.

14. Informant E D Sennett (Father)

(Address) Clarkston, Wash

15. Filed Dec 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1929, to Nov. 14, 1929

that I last saw h~~im~~ alive on Nov. 14, 1929

and that death occurred, on the date stated above, at ..... m.

The ~~CAUSE OF DEATH~~* was as follows: Bilateral bronchopneumonia

(duration) 5 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Congenital

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) L Blanchard M. D.

11/15, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clarkston, Wash — Date of Burial: 11/15/29

20. Undertaker: H.R. Merchant — Address: Clarkston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68417

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sadie M. Morley.

(a) Residence. No. 1108 - 10th St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. E. Morley.

6. DATE OF BIRTH (month, day and year) Mar 30 1884

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	7	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS

10. NAME OF FATHER Chas. Batten
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Mary Batten
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Chas E. Morley
(Address) Lewiston Idaho.

15. Filed Dec 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17, 1929, to Nov 20, 1929
that I last saw her alive on Nov 19, 1929
and that death occurred, on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
several years.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Bronchopneumonia
(Signed) Paul W Johnson, M. D.
Nov 25, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	11/21 1929
20. Undertaker	Address
Vassar Mortuary	Lewiston Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68418

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 1445 Main St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Aaron Clifford Barbour 62

(a) Residence. No. 1445 Main St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: 1/8 Indian
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): 9/13/29.

7. AGE: Years — Months 2 Days 9 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lewiston Idaho

PARENTS
10. NAME OF FATHER: Joe Barbour
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Helena Montana
12. MAIDEN NAME OF MOTHER: Mary Owen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ogden Utah.

14. Informant: Joe Barbour
(Address): Lewiston Idaho.

15. Filed Dec 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 22nd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-22-29, 19__, to 11-22-29, 19__
that I last saw him alive on 11-22-29, 19__
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows: Staticus Lymphaticus of Thymus Gland.
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs & symptoms
(Signed) H. Rouse, M. D.
11/23, 1929 (Address) Lewiston Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho. Date of Burial: 11/23 1929

20. Undertaker: Brower-Dann E Address: Lewiston Idaho

Dr Johnson

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68419

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Jennie McNee

(a) Residence. No. Clarkston wash St. 2 days
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 49 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: A J McNee

6. DATE OF BIRTH (month, day and year): Sept 14th 1872

7. AGE — Years: 57 | Months: 2 | Days: 8 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: Geo England
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: — Pattimore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: A J McNee
(Address): Clarkston Wn

15. Filed Dec 1, 1929. Susan E. Bruce, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929 to Nov 22, 1929
that I last saw her alive on Nov 22 1929
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH was as follows:
Lobar Pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Clarkston Wash
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Paul B Johnson, M. D.
Nov 25 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston — Date of Burial: Dec 1 1929
20. Undertaker: Vassar Mortuary — Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Clark

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68420

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

1610

2. FULL NAME Mary Simpson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6. DATE OF BIRTH (month, day and year): Nov 24 - 1929

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
				2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Lewiston Idaho

PARENTS

10. NAME OF FATHER: J. M. Simpson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Oregon
12. MAIDEN NAME OF MOTHER: Flora Lappnacci
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Washington

14. Informant: J. M. Simpson
(Address): No Lewiston Route 1

15. Filed Dec 1, 1929. Susan E Bruce, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24, 1929, to Nov 24, 1929, that I last saw h[illegible] alive on Nov 24, 1929, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows: Premature infant

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W D Clark, M. D.
11/26, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	11/26/1929

20. Undertaker: Vassar's — Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68422

PLACE OF DEATH

County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Douglas C. Lovd

(a) Residence. No. Bellinger Hotel St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 24 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	78	4	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Banker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER John Lovd
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Alice Fuller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Margaret Lovd
(Address) Spokane, Wash.

15. Filed Dec 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1929 to Nov 26, 1929
that I last saw him alive on Nov 23, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J W Kyle M. D.
11-26, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wn	1929
20. Undertaker	Address
Bowes-Hamm Co	Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68422

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1069
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 129

2. FULL NAME Eliza Lyn Vanroy

(a) Residence. No. 4th & Diagonal St. Clarkston Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of B. S. Vanroy

6. DATE OF BIRTH (month, day and year) Feb. 17

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant B. S. Van Roy
(Address) 4th & Diagonal Clarkston Wash.

15. Filed Dec 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/22, 1929, to 11/25, 1929, that I last saw h[er] alive on 11/24, 1929, and that death occurred, on the date stated above, at Lewiston Idaho.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? What test confirmed diagnosis?

(Signed) H. McElvain, M. D.
11/26, 1929 (Address) Asotin Wash

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	11/27 19
20. Undertaker Vassar Mortuary Den	Address Lewiston Idaho

RECEIVED DEC 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68423

PLACE OF DEATH
County of Nez Perce
City of Juliaetta R.D.

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard Blankenship 101B

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Blankenship

6. DATE OF BIRTH (month, day and year): Feb. 5 - 1893

7. AGE: Years 36 | Months 10 | Days 3 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Troy, Ida

PARENTS

10. NAME OF FATHER: Thomas Blankenship
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Geo.
12. MAIDEN NAME OF MOTHER: Keaun
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Geo

14. Informant: Robert Thornley
(Address) Leland, Ida.

15. Filed Dec 9, 1929 B. F. Hart Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7, 1929, to Dec. 8, 1929
that I last saw him alive on Dec. 8, 1929
and that death occurred, on the date stated above, at 6 p. m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. H. Field, M. D.
Dec. 8, 1929 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cameron Cemetery — Date of Burial: Dec 10 1929
20. Undertaker: none — Address:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68425

PLACE OF DEATH

County of Oneida

City of Malad

Registration District No. 26

Primary Registration District No. 2064

Local Registrar's No. 35

(No.) 177

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Berlene Hawks

(a) Residence. No. Portage Utah St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July-5-1928

7. AGE Years 1 Months 4 Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ~~Malad~~ Portage Ut.

PARENTS

10. NAME OF FATHER Abraham D. Hawks

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mesa Arizona

12. MAIDEN NAME OF MOTHER Pearl L. Halford.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Portage Ut.

14. Informant DeRoy Hawks
(Address) Portage Utah

15. Filed 11-30, 1929 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18, 1929, to Nov 19, 1929
that I last saw her alive on Nov 19, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows: Poisoning Papaine accidental

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Portage

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Stomach washing

(Signed) [signature], M. D.

11/19, 1929 (Address) Malad

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Portage Ut. Date of Burial Nov. 21 1929

20. Undertaker J. Guy Benson Address Malad Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

REC'D DEC 5 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida

City of Malad

Registration District No. 26

Primary Registration District No. 2069

(No. ..... St.)

File No. 6342

Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Richards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: July (Month) 31 (Day) 1905 (Year)

7. AGE: 24 Yrs. 3 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad Oda.

10. NAME OF FATHER: Evan M. Richards

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Letitia Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Malad Oda.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Richards
(Address) Malad Oda.

15. Filed 11-30 1929 J. M. Kerns
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1929 to Nov 11 1929
that I last saw h.im alive on Nov. 9, 1929,
and that death occurred on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Lobar pneumonia, Pulmonary tuberculosis
(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) J. P. Grant M. D.
Nov 12 1929 (Address) Malad, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Oda	Nov. 14 1929
20. UNDERTAKER	**ADDRESS**
J. Guy Akman	Malad Oda

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

REC... DEC 5 1929

CERTIFICATE OF DEATH

Registration District No. 26

Primary Registration District No. 2069

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 68428

Registered No. 32

1. PLACE OF DEATH

County of Oneida

City of Malad

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matilda W. Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Feb. (Month) 2 (Day) 1884 (Year)

7. AGE: 41 Yrs. 8 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad Idaho

10. NAME OF FATHER: Samuel H. Williams

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Matilda Sleed

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Percy L. Hansen

(Address) Malad Ida

15. Filed Nov. 30 1929 J. M. Kraus Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1926 to Oct. 30 1929, that I last saw h.. alive on Oct 20 1929, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows: Tumor of Brain

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Kraus M. D.

11/30 1929 (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Ida	Nov. 2 1929

20. UNDERTAKER	ADDRESS
J. Guy Beeman	Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19

RECEIVED DEC 11 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Owyhee

~~City of~~ Hot Springs

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 74

Primary Registration District No. 2151

(No. ..... St.)

File No. 68429

Registered No. 54

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John S. Hodge 100a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Nov. (Month) 12th (Day) 1839 (Year)

7. AGE: 90 Yrs. — Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. S. Zacher

(Address) Mt Home Idaho

15. Filed Dec. 10 1929 W. J. Eikenbeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 28th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1929, to Nov. 28 1929 that I last saw him alive on Nov. 16, 1929, and that death occurred on the date stated above, at 3.35 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia following Grip

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Evans M. D.

12-6-1929 (Address) Mtn Home Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Hot Springs, Idaho

DATE OF BURIAL: 11-30 1929

20. UNDERTAKER: G. S. Zacher

ADDRESS: Mt. Home Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED DEC 6, 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68450

Registration District No. 84
Primary Registration District No. 2020
Local Registrar's No. 20

PLACE OF DEATH

County of Owyhee
~~City of~~ Indian Cove near Hammett Ida.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leonidas Pancoast 49

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 3-14-1858

7. AGE Years	Months	Days	If LESS than 1 day,
71	8	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bellbrook Ohio

PARENTS

10. NAME OF FATHER Brazila Pancoast
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Jersey
12. MAIDEN NAME OF MOTHER Bridgeman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant G. L. Zacher
(Address) Mt. Home Idaho

15. Filed Dec 4, 1929 A. Thedinga Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 2nd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1st, 1929, to Dec. 2nd, 1929
that I last saw him alive on Dec. 2nd, 1929
and that death occurred, on the date stated above, at 11-45 a m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. W. Davis, M. D.
Dec. 2nd, 1929 (Address) Glenns Ferry Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation~~, or Removal: Hartford City Ind. Date of ~~Burial~~: Dec 4 1929

20. Undertaker: G. L. Zacher Address: Mt. Home Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 6, 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Mt Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34

Primary Registration District No. 2020

(No. ..... St.)

File No. 68431

Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harlon Theodore Pickrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April 24, 1845 (Month) (Day) (Year)

7. AGE: 84 Yrs. 6 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Jacob Pickrell

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Rachel Marmon

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C M Pickrell

(Address) Mountain Home, Ida

15. Filed Nov 27 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 135

Oct (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-19-1929, to 10-27-1929, that I last saw him alive on 10-27-1929, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows: Prostrato-Cystitis

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration) 6 yrs. ..... mos. ..... ds.

(Signed) T. E. Evans M. D.

11-23-1929 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Mountain Home

DATE OF BURIAL: 10-28 1929.

20. UNDERTAKER: G. S. Zacher

ADDRESS: Mt Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. [illegible] RECEIVED DEC 6, 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Mt Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34

Primary Registration District No. 2020

(No. ..... , ... St.)

File No. 68432

Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah E. Reed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Divorced (Write the word.)

6. DATE OF BIRTH: Aug. (Month) 1 (Day) 1853 (Year)

7. AGE: 76 Yrs. 2 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Johnson

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ora Cannon

(Address) Mt Home

15. Filed Nov 27 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1929 (Year) 112

17. I HEREBY CERTIFY, That I attended deceased from 10-4-1929, to 10-5-1929, that I last saw her alive on 10-5-1929, and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows: Pyloric Stenosis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. E. Evans M. D.

10-23-1929 (Address) Mtn. Home

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Mountain Home

DATE OF BURIAL: 10-7 1929

20. UNDERTAKER: G. C. Zacher

ADDRESS: Mt Home

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 2 1929

PLACE OF DEATH

County of Payette

City of Fruitland

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 51

Primary Registration District No. 2130

(No. .....)
(If death occurred in a hospital or institution, give its name ~~instead~~ of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68433

Local Registrar's No. 5

108

2. FULL NAME Herbert A. Henderson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W.

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Mildred Henderson

6. DATE OF BIRTH (month, day and year) June 3 1884

7. AGE 45 Years | Months 5 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner Quartz

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Jas. Henderson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mildred Henderson
(Address) Fruitland

15. Filed Nov 26, 1929 Mrs Wm T. Drysdale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from saw him a few times during past two yrs, 19..., to that I last saw him alive on Nov 24, 1929 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:
Chronic infectious granuloma of cervical glands.
Probably actinomycosis - from contact with animals.
..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Oregon

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Wm T. Drysdale, M. D.

11-26, 1929 (Address) New Plymouth

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ontario Ore. | Date of Burial: Nov 26 1929

20. Undertaker: J. H. Adair | Address: Peterson Furn Co Payette Ida

RECEIVED DEC 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68434

PLACE OF DEATH
County of Payette
City of Fruitland

Registration District No. 51
Primary Registration District No. 2130
Local Registrar's No. 4

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jemima Paxton
(a) Residence. No. Fruitland Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. many yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chas C. Paxton

6. DATE OF BIRTH (month, day and year) Sept 9 - 1839

7. AGE 90 Years | 1 Months | 18 Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) Hancock Co. Ill
(State or country)

PARENTS
10. NAME OF FATHER John Cameron
11. BIRTHPLACE OF FATHER (city or town) unknown
(State or Country)
12. MAIDEN NAME OF MOTHER Lee
13. BIRTHPLACE OF MOTHER (city or town) unknown
(State or Country)

14. Informant Dr C C. Paxton
(Address) Fruitland Ida

15. Filed Oct 27, 1929. Mrs Wm J. Drysdale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 27, 1929
that I last saw her alive on Oct 10, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

..... (duration) many yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical evidence
(Signed) Wm J. Drysdale, M. D.
10-27, 1929 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Papillion Nebr
Date of Burial: Nov 1 1929

20. Undertaker: Glenn C Landon
Address: Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68435

PLACE OF DEATH
County of Payette
City of Fruitland

Registration District No. 51
Primary Registration District No. 2130
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 3

2. FULL NAME Mary E Stegner

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

9 B

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F
4 COLOR OR RACE: W
5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 9 1844

7 AGE: 85 Years, Months 5, Days 1
If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ind

PARENTS
10 NAME OF FATHER: Anderson
11 BIRTHPLACE OF FATHER (city or town) (State or country): ✓ ✓
12 MAIDEN NAME OF MOTHER: ✓ ✓
13 BIRTHPLACE OF MOTHER (city or town) (State or country): ✓ ✓

14 Informant: E A Stegner
(Address) Fruitland Ida

15 Filed Sept 11, 1929 Mrs Wm J. Drysdale Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 10 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1926, 19....., to Sept 10, 1929, that I last saw her alive on Aug 10, 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

..... (duration) many yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): senility

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? clinical evidence

(Signed) Wm J. Drysdale, M. D.
9-11, 1929 (Address) Near Plymouth Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Payette Ida
Date of Burial: Sept 11 1929

20. Undertaker: J H Adair
Address: Pherson Turn Co Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED DEC 2 1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 5

Primary Registration District No. 2009

File No. 68126

County of Bear Lake

City of Mrs Plymouth (No. ....., ... St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dufaut Dodds - 161a

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Infant

6. DATE OF BIRTH.

Oct (Month) 24 (Day) 1929 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..1.... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... ✓

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Daniel Dodds

11. BIRTHPLACE OF FATHER Texas (State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Dufur

13. BIRTHPLACE OF MOTHER Arizona (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Dodds

(Address) Mrs Plymouth Ida

15.

Filed Oct 25 1929 Wm J. Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth 191..., to ..... 191..., that I last saw him alive on Oct 24 1929, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Insufficient foetal development.
6th month gestation

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Mother had had some sort of suppression operation.

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm J. Drysdale M. D.

11-27-1929 (Address) Mrs Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mrs Plymouth Ida	Oct 24 1929

20. UNDERTAKER	ADDRESS
Daniel Dodds	Mrs Plymouth

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., FTRS. & SORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. RECEIVED DEC 2 1929

County of Payette

City of New Plymouth

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5

Primary Registration District No. 2009

(No. ..... St.)

File No. 68437

Registered No. 5

161a

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Dodds

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant Twin 1 (Write the word.)

6. DATE OF BIRTH. Oct (Month) 24 (Day) 1929 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 1/2 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Daniel Dodds

11. BIRTHPLACE OF FATHER (State or Country) Texas

12. MAIDEN NAME OF MOTHER Elizabeth Dufur

13. BIRTHPLACE OF MOTHER (State or Country) Arizona

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Dodds

(Address) New Plymouth Ida

15. Filed Oct 25 1929 Wm T. Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth 191..., to ..... 191...,

that I last saw him alive on Oct 24 1929,

and that death occured on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Insufficient foetal development 6th month gestation

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) (Mother had had some sort of suspension operation)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm T. Drysdale M. D.

11-27 19.... (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Plymouth Ida

DATE OF BURIAL: 10-24 1929

20. UNDERTAKER: Daniel Dodds

ADDRESS: New Plymouth

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SGRS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68438

PLACE OF DEATH

County of Payette

City of N Plymouth

Registration District No. 5

Primary Registration District No. 2009 196

Local Registrar's No. 4

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George M. Darnell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 2 1863

7. AGE Years 66 Months 1 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ~~Farmer~~ Ditch Rider

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Farmers Co-op Irrigation Co.

9. BIRTHPLACE (city or town) (State or country) Wis

PARENTS

10. NAME OF FATHER Daniel Darnell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wis

12. MAIDEN NAME OF MOTHER Anna Remmals

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant J. H. Adair
(Address) Payette Ida

15. Filed 11-26, 1929. Wm J Drysdale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Accidental Electrocution

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. H. Adair Coroner ~~M. D.~~

11/25, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal New Plymouth — Date of Burial Oct 27 1929

20. Undertaker J H Adair Pierson Furn Co — Address Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68439

PLACE OF DEATH

County of Power
City of American Falls

Registration District No. 23
Primary Registration District No. 2072
(No.) 74a
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 31

2. FULL NAME Tauline S. Flemmer
(a) Residence. No. 20 Miles West of Am Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Flemmer

6. DATE OF BIRTH (month, day and year) Aug 7 1852

7. AGE Years 77 Months 3 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10. NAME OF FATHER Carl Fisher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Cartena Schindler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant A Winter and
(Address) American Falls, Idaho

15. Filed Nov. 27, 1929 Emerson Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9, 1929, to Nov 24 1929
that I last saw her alive on Nov 24, 1929
and that death occurred, on the date stated above, at 4:15 P.m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. F. Schiel, M. D.
Nov 25, 1929 (Address) Am. Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pleasent Valley
Date of Burial: 11/28 1929

20. Undertaker: A. W. Davis
Address: American Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68440

PLACE OF DEATH

County of Power

City of American Falls, Idaho

Registration District No. 25

Primary Registration District No. 2072

Local Registrar's No. 30

(No. Bethony Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dorothy Arleen Hartley

(a) Residence. No. ____ St. ____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 24 1926

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
3	11	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ____

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9. BIRTHPLACE (city or town) Am Falls
(State or country) Ida.

PARENTS

10. NAME OF FATHER James Hartley Jr

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Rockland, Idaho

12. MAIDEN NAME OF MOTHER Jenny Conroe

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Neb

14. Informant James Hartley Jr.
(Address) American Falls, Idaho

15. Filed Nov. 3, 1929 Emerson Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 2nd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-23, 1929, to Nov. 2, 1929
that I last saw her alive on Nov. 2, 1929
and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis?

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY ____
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) V. G. Tyrrell, M. D.

Nov 2nd, 1929 (Address) Am Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rockland, Idaho	11/3/29 19

20. Undertaker A W Davis Address Am Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68441

County of Power

City of American Falls, Idaho

Registration District No. 25

Primary Registration District No. 2072

Local Registrar's No. 29

(No. Bethony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Louis Gene Ralph

(a) Residence. No. Rockland, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 18 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Logan, Utah

PARENTS

10. NAME OF FATHER L.T.Ralph

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Marie Thorpe

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant L. T. Ralph
(Address) Rockland, Idaho

15. Filed Nov 1, 1929 Gwenen Nolte Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 1st (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-31, 1929, to 11-1, 1929

that I last saw him alive on 11-1, 1929

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows: Pneumonia (Edema)

Bronchial

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) V. G. Logan, M. D.

11/1/29, 19 (Address) Am Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Logan, Utah

Date of Burial: 11/3/29

20. Undertaker: A W Davis

Address: American Falls Ida

RECEIVED DEC 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6842

Local Registrar's No. 8

PLACE OF DEATH

County of Shoshone

City of Avery

Registration District No. 127

Primary Registration District No. 2400

(No.) 31

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Dunlap

(a) Residence. No. — St.
(Usual place of abode)
Length of residence in city or town where death occurred. 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Reno Paiono, deceased

6. DATE OF BIRTH (month, day and year) April 14 1878

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	7	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Locomotive Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Northwestern RR Co

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER John Dunlap

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Margret Leslie

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs. Margret Manley
(Address) Avery - Idaho

15. Filed Nov. 16, 1929 C Bracy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1929, to Nov. 15, 1929
that I last saw him alive on Nov. 15, 1929
and that death occurred, on the date stated above, at 10.35 p m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

about
(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum, Test of

(Signed) C Bracy, M. D.

Nov. 16, 1929 (Address) Avery Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Via St. Maries, Ida. Date of Burial 19

Belle Plaine, Iowa

20. Undertaker Geo. L. Mitchell Address St. Maries, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68443

PLACE OF DEATH

County of Lincoln

City of Shoshone

Registration District No. 16

Primary Registration District No. 2016

Local Registrar's No. 14

(No. Stowell Residence)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ~~Wing~~ Lee Hock

164

(a) Residence. No. Shoshone Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Chinese

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 80 Years, Months: No, Days: No, If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Labor.

(b) General nature of industry, business, or establishment in which employed (or employer): Farmer.

(c) Name of employer: Self.

9. BIRTHPLACE (city or town) (State or country): China.

PARENTS

10. NAME OF FATHER: Not Known.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known.

12. MAIDEN NAME OF MOTHER: Not Known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): No.

14. Informant: C W Dill

(Address)

15. Filed: Aug 20, 1929 J L Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from None, 19__, to ___, 19__

that I last saw him alive on Aug 20, 1929,

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Senility.

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary): Labor. Exposure.

(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? Shoshone Idaho.

Did an operation precede death? No Date of ___

Was there an autopsy? No.

What test confirmed diagnosis? Found dead.

(Signed) C W Dill M. D.

Aug 20, 1929 (Address) Shoshone Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone

Date of Burial: 8-20 1929

20. Undertaker: C E Hickok

Address: Shoshone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68444

PLACE OF DEATH
County of Lincoln
City of Shoshone

Registration District No.
Primary Registration District No.
(No. Dill Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

198

2. FULL NAME Alano Anaya
(a) Residence. No. Dietrich Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Approx 30 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Section Hand
(c) Name of employer: O S L Rail Road Co

9. BIRTHPLACE (city or town) (State or country): New Mexico

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Harlan D. Hurst
(Address) Prosecuting Attorney

15. Filed July 13, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1929, to July 12, 1929, that I last saw his alive on July 12, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Knife wound, of abdomen, running, bronze of Coeliac axis and causing Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Drinkin fight.

(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Dietrich Idaho.
Did an operation precede death? No Date of No
Was there an autopsy? Yes.
What test confirmed diagnosis? Effect of abdomen & [illegible]
(Signed) [signature] M. D.
July 13, 1929 (Address) Shoshone Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone
Date of Burial: 7-12 1929

20. Undertaker: C E Hickok
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68446

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No.) 88B
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 47

2. FULL NAME Charles Krone

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 8, 1855

7. AGE Years 73 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10. NAME OF FATHER: Krone
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: no inf
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Oscar Krone
(Address) Kellogg, Idaho

15. Filed Nov. 15, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Myocarditis Chr
Several
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Mowery Corone M.D.
9/30, 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Greenwood Cemetery
Date of Burial: Sept. 23 1929

20. Undertaker: M. C. Shanahan
Address: Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REC'D DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68447

PLACE OF DEATH
County of Shoshone
City of Kellogg
Registration District No.
Primary Registration District No.
Local Registrar's No. 48
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Caughell

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 13, 1909

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	4	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Miner
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Ernest E Caughell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Miss Wilkinson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant W H Caughell
(Address) Kellogg, Idaho

15. Filed Nov 8, 1929 Mrs Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH Kennett

16. DATE OF DEATH Nov 5, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27, 1929, to Nov 5, 1929, that I last saw h~~im~~ alive on Nov. 5, 1929, and that death occurred, on the date stated above, at 5350 m.

The CAUSE OF DEATH* was as follows:
Influenza
Double Lobar Pneumonia
(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)
Pneumonia (duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Geo H Kennett M. D.
Nov 8, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg. Ida	Nov 9 1929
20. Undertaker	Address
M. C. Thomkins	Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68448

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 49

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kenneth Leslie West

184

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret West

6. DATE OF BIRTH (month, day and year)

7. AGE: 18 Years | Months: 2 | Days: 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Smelter
(b) General nature of industry, business, or establishment in which employed (or employer): Sample Mill
(c) Name of employer: Bunker Hill Sullivan

9. BIRTHPLACE (city or town) (State or country): Moose Jaw Sask. Canada.

PARENTS

10. NAME OF FATHER: Fremont E West.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Boyaville Wisc
12. MAIDEN NAME OF MOTHER: Minnie Van Tassel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Boyceville Wisc

14. Informant: Robert Van Tassel
(Address): Kellogg, Idaho

15. Filed Nov. 15, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ....., 19....., to ....., 19.....
that I last saw him alive on Nov. 14, 1929
and that death occurred, on the date stated above, at 4 p m.
The CAUSE OF DEATH* was as follows:
Gunshot wound abdomen
Accidental
..... (duration) ..... yrs. few min
CONTRIBUTORY (Secondary): None
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) H. C. Mowery Corone M.D.
1/15/29 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane, Wash | Date of Burial: Nov 16, 1929

20. Undertaker: M. C. Thornhill | Address: Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68449

PLACE OF DEATH
County of Twin Falls
City of Burger

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Wayne L. Wygal

(a) Residence. No. Berger St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

101a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 12 / 1882

7. AGE: Years 47 Months 8 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) Invalid
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Colo

PARENTS
10. NAME OF FATHER W. H. Wygal
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Sarah Stephenson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Mary Wygal
(Address) Filer

15. Filed 11-22 1929 Dr. D. M. Cowgiee Registrar

MEDICAL CERTIFICATE OF DEATH Clancheck

16. DATE OF DEATH Nov (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29, 1929, to Nov 2, 1929
that I last saw him alive on Nov 2, 1929
and that death occurred, on the date stated above, at 9.30 a m.
The CAUSE OF DEATH* was as follows:
lobar pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
none (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H. W. Clancheck M. D.
Nov 2, 1929, (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer Cemetry — Date of Burial: Nov 4 1929

20. Undertaker: F. Gaske — Address: Twin Falls

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68451

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sophia Dalley

(a) Residence. No. 287 Lincoln St. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Robert B Dalley

6. DATE OF BIRTH (month, day and year) May 28 1867

7. AGE Years	Months	Days	If LESS than 1 day,
62	5	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Wm Dalley Sr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Sophia Farrow
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Robert B Dalley
(Address) Twin Falls

15. Filed 11-22nd, 1929. Dr D M Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH (Dr Davis)

16. DATE OF DEATH Nov (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 —, 1928, to Nov 3, 1929
that I last saw her alive on Oct — 1 —, 1928
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Apoplexy —
(repeated strokes)
(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) J H Davis M. D.
Nov 4, 1929 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	Nov 5 1929
20. Undertaker E Drake	Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68452

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No.
Primary Registration District No.
(No. In Murtaugh Reservoir)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

152

2. FULL NAME Raymond L. Moreland
(a) Residence. No. 237 2nd Ave East St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Doris Moreland.

6. DATE OF BIRTH (month, day and year) Dec 20 1905

7. AGE: Years 23, Months 11, Days 13. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Idaho Power Co.

9. BIRTHPLACE (city or town) (State or country): Colorado

PARENTS

10. NAME OF FATHER: Charles P. Moreland
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Ella Webster
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa.

14. Informant: Mrs. Doris Moreland
(Address) 237 2nd East City.

15. Filed 11-22nd, 1929 Dr D. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — , 19 , to , 19
that I last saw him ~~alive~~ dead on Nov. 5, 1929
and that death occurred, on the date stated above, at about 1 P m.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
Boat capsized while Hunting ducks
on Murtaugh Lake - Body recovered
Nov 5th (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of — — —
Was there an autopsy?
What test confirmed diagnosis?
(Signed) F. C. Drake County Coroner, ~~M.~~ D.
Nov. 7, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: Nov. 7 1929

20. Undertaker: P. J. Grossman
Address: Twin Falls.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68453

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No. 811- West Main)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eugene Leroy Nergaard

(a) Residence. No. 811- West Main St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 4 - 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	— 30

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Fridtjof Nergaard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minnesotta
12. MAIDEN NAME OF MOTHER Melvina Dougherty
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Fridtjof Nergaard
(Address) 811-W. Main Twin Falls Ida

15. Filed 11-22 ud, 1929. Dr D. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 4 (Day) 1929 (Year) Lamb

17. I HEREBY CERTIFY, That I attended deceased from Nov 4, 1929, to Nov 4, 1929, that I last saw h[illegible] alive on Nov 4, 1929, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows: Tumor of the abdominal Cavity

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Prematurity
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? In utero
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Autopsy

(Signed) H C Lamb M. D.
Nov 4th 1929 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Nov 5 1929

20. Undertaker J E Drake — Address Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68454

Registration District No.
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
(No. Twin Falls County Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Catherine anne McKee

(a) Residence. No. Twin Falls Route 1 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

16A

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) oct 4 - 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	0	0	6 hrs. or ____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) Twin Falls Idaho.

PARENTS

10. NAME OF FATHER Valley J. McKee

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Mable Greenstreet

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant N. J. McKee
(Address) Twin Falls Ida Route 1.

15. Filed 11-23rd, 1929. Dr. D. M. Cougill, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-5, 1929, to 11-5, 1929
that I last saw her alive on 11-5-, 1929
and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:
Premature Delivery:
Near 7 months Gestation
Obstruction in Circulation in Cord
due to Knot (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical exam
(Signed) Dr John R Morgan, M. D.
11-5-, 1929 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	11-5 1929
20. Undertaker	Address
White Mortuary	Twin Falls Idaho.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68456

PLACE OF DEATH
County of Twin Falls
City of Kimberly
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. at home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Durset Thomas Turner

(a) Residence. No. Kimberly Idaho St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 5 1851

7. AGE: Years 78 | Months 10 | Days 4 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): (Retired)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Tenn.

PARENTS

10. NAME OF FATHER: Mortica Turner
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ky.
12. MAIDEN NAME OF MOTHER: Cathima Hubbard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ky.

14. Informant: A. W. Turner
(Address): Kimberly

15. Filed 11-23, 1929. Dr. D. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5, 1929, to Nov. 9, 1929, that I last saw him alive on Nov. 9, 1929, and that death occurred, on the date stated above, at 2.00 m.

The CAUSE OF DEATH* was as follows:
Influenza
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Hypostatic pneumonia
(duration) yrs. mos. 1/2 ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical -

(Signed) J. M. Davis M. D.
Nov-11, 1929 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Nov-11 1929
20. Undertaker	Address
T. J. Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68457

PLACE OF DEATH
County of Twin Falls
City of Kimberly

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ramon Gonzales

(a) Residence. No. Kimberly Route 2 St. 31 Hailey
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 29/1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	2	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mexico

PARENTS
10. NAME OF FATHER Jesus Gonzales
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico
12. MAIDEN NAME OF MOTHER Morales
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico

14. Informant Joe Gonzales
(Address) Twin Falls Ida

15. Filed 11-23, 1929 Dr D. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to Nov 9, 1929
that I last saw h[illegible] alive on Nov 6, 1929
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(duration) ? yrs. mos. ds.
CONTRIBUTORY (Secondary) Arthritis
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no What test confirmed diagnosis? X-Ray & clinical examination
(Signed) George E. Hailey, M. D.
Nov 10, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	Nov 11 1929
20. Undertaker	Address
J E Drake	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68458

PLACE OF DEATH
County of Twin Falls
City of (1) (1)
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. at home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1616

2. FULL NAME Robert I. Pettet

(a) Residence. No. 139 5th St. So St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Oct. 19 1929

7. AGE — Years: 0 — Months: 0 — Days: 23 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Labor
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Twin Falls Ida.

PARENTS

10. NAME OF FATHER: Oscar C Pettet
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wisc.
12. MAIDEN NAME OF MOTHER: Florence Wagner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Colo.

14. Informant: Oscar C Pettet
(Address) 139 5th St. So City

15. Filed 11-23-29, 1929. Dr David M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19, 1929, to Nov. 12, 1929
that I last saw him alive on Nov. 12, 1929
and that death occurred, on the date stated above, at 5. P. m.
The CAUSE OF DEATH* was as follows:
Patent ductus Arteriosus (Blue Baby)
Pneu.
(duration) yrs. mos. 23 ds.
CONTRIBUTORY (Secondary): Premature birth.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) J. E. Langenwalter, M. D.
Nov 14, 1929 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Nov. 14 1929
20. Undertaker: P. J. Grossman — Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68459

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Byron Brown

(a) Residence. No. Hospital St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

44B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years about 60 | Months — | Days — | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Mr Jackson

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: T. E. Drake County Coroner
(Address) Twin Falls Ida

15. Filed 11-23, 1929. Dr David M. Courgee Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12, 1929, to Nov 13, 1929

that I last saw him alive on Nov 13, 1929

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows: Myocarditis chr.

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. Russell Weaver, M. D.

11-14, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salt Lake City | Date of Burial: Nov 19 9

20. Undertaker: T. E. Drake | Address: Twin Falls

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68460

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.) 49
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna Hesp

(a) Residence. No. Twin Falls Idaho R.F.D. 3 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Hesp

6. DATE OF BIRTH (month, day and year) Oct 31-1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	0	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Daniel Kaut
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio Penn
12. MAIDEN NAME OF MOTHER Sarah Burger
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio Penn

14. Informant Thomas Hesp
(Address) Twin Falls R.F.D. 3

15. Filed 11-23rd, 1929 Dr. David M. Courger Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November (Month) 17th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
For last four years to 11-17, 1929
that I last saw her alive on 11-17, 1929
and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:
Carcinoma Left Lung.
(duration) Several mos. — ds.
CONTRIBUTORY (Secondary) Carcinoma Left Breast (removed)
(duration) Several mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of Dec. 13th 1927.
Was there an autopsy? no.
What test confirmed diagnosis? General appearance, Symptoms etc
(Signed) Dr. C. A. Ennes, M. D.
11-17, 1929 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Nov 19 1929
20. Undertaker	**Address**
White Mortuary	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68461

PLACE OF DEATH
County of Twin Falls
City of 11 11

Registration District No. 37
Primary Registration District No. 2080
(No. Co. Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

129

2. FULL NAME Julia A. Wilson
(a) Residence No. Kimberly St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Nov. 23 1845
7. AGE Years 83 Months 11 Days 25 If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Mich.

PARENTS
10. NAME OF FATHER Russell Munger
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Eliza Spears
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant A J Wilson
(Address) Kimberly Ida
15. Filed 11-30, 1929 D. McCowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 19 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1928, to Nov. 19, 1929
that I last saw her alive on Nov. 12, 1929
and that death occurred, on the date stated above, at 3 15 a m.
The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis and arterio sclerosis
(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) J N Davis, M. D.
Nov. 21, 1929 (Address) Kimberly Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial Nov. 20 1929
20. Undertaker T. J. Grossenau
Address Twin Falls

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68462

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1080
(No. 99)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME John Edward Wirsching
(a) Residence. No. St. Dr Weaver
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 3 1850

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	8	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS
10. NAME OF FATHER X X Wirsching
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant C. J. Wirsching
(Address) Twin Falls

15. Filed 11-30, 1929 H. M. Cowgill Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 21 1929 8-5
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929, to Nov. 21, 1929
that I last saw him alive on Nov. 21, 1929
and that death occurred, on the date stated above, at 8 a.m.
The CAUSE OF DEATH* was as follows:
Angina pectoris.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cardiac insufficiency
(duration) (2) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E. D. Weaver M. D.
11/26, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Nov 25 1929

20. Undertaker	Address
F. E. Wicke	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68463

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 2080
(No. Co. Gene Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

144

2. FULL NAME Ella McCoy
(a) Residence. No. R.F.D. 3 Jerome St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of G. L. McCoy

6. DATE OF BIRTH (month, day and year) Aug 6 1900

7. AGE Years 29 Months 3 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS
10. NAME OF FATHER Arnold Merk
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant G. L. McCoy
(Address) Jerome Ida R.F.D. #3

15. Filed 11/30, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929, to Nov 23, 1929
that I last saw her alive on Nov 23rd 1929,
and that death occurred, on the date stated above, at 10 30 a.m.
The CAUSE OF DEATH* was as follows:
Streptococcus infection General (Purpura Hemorrhagica Secondary)
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) ① Appendicitis acute ② Miscarriage spontaneous
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Jerome Ida.
Did an operation precede death? yes Date of Nov 20th 29
Was there an autopsy? no
What test confirmed diagnosis? Operations.
(Signed) D L Alexander, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial 19

20. Undertaker P J Grossman
Address Twin Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68464

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

131

2. FULL NAME Sara Isabelle Hunter

(a) Residence. No. Kimberly Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lewis F. Hunter

6. DATE OF BIRTH (month, day and year): Oct 1 - 1885

7. AGE: Years 44, Months 1, Days 26. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ogden Utah

PARENTS

10. NAME OF FATHER: Samuel F. Barrett
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wilshire England
12. MAIDEN NAME OF MOTHER: Elizabeth Neybee
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Lewis F. Hunter
(Address): Kimberly, Ida

15. Filed 11-30-, 1929 D. M. Cowgill H.W. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19th, 1929, to Nov 26, 1929
that I last saw her alive on Nov 26, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Uremia
(duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary): Interstitial nephritis High Blood Pressure
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? Yes Date of Nov 23-29
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. E. Lamb M. D.
Nov 29, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby Idaho
Date of Burial: 19

20. Undertaker: White Mortuary Inc
Address: Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC[illegible] DEC 11 1929

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68465

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Un named Male child — Strickling

(a) Residence. No. Hull, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, 22 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hull, Idaho

PARENTS

10. NAME OF FATHER Stanley Strickling

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Seattle Wash

12. MAIDEN NAME OF MOTHER Margaret Peters

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wapun - Wis

14. Informant John W. Laughlin M.D.
(Address) Twin Falls Ida

15. Filed 11-30th, 1929. D. M. Cowgill M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1929, to Nov. 27, 1929

that I last saw him alive on Nov. 26th, 1929

and that death occurred, on the date stated above, at 59 m.

The CAUSE OF DEATH* was as follows: Premature birth (6 mos) overwork on mother's part

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) John W. Laughlin M. D.

12-2, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68466

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2081
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Leslie David Lowry

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6. DATE OF BIRTH (month, day and year): March 13-

7. AGE: Years 23 | Months 7 | Days 25 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer): General
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Dresden - Kansas

PARENTS

10. NAME OF FATHER: N. D. Lowry
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Minnesota
12. MAIDEN NAME OF MOTHER: Eliza Havird
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Mrs W. D. Lowry
(Address): Buhl Ida

15. Filed Nov. 7, 1929. J. Hillerby Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Nov 7, 1929, that I last saw him alive on Nov 7, 1929, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows: Sarcoma right groin (Type undetermined) Probable metastasis in lungs

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. R. Berry M.D.

Nov 7, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl, Idaho	Nov. 9th 1929
20. Undertaker	Address
L. Johnson	Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68467

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Jonathan Jackson

(a) Residence. No. ..... St. 31
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rachail Minerva Jackson

6. DATE OF BIRTH (month, day and year) Sept 4th 1838

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
91	2	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10. NAME OF FATHER Madison Jackson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Knaw
12. MAIDEN NAME OF MOTHER Eunice Worthington
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Knaw

14. Informant W. S. Stewart
(Address) Buhl Idaho

15. Filed Nov. 18, 1929. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 15th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1929, to Nov 15, 1929
that I last saw him alive on Nov. 10 1929
and that death occurred, on the date stated above, at 11 45 P m.
The CAUSE OF DEATH* was as follows:
Active Chronic bilateral pulmonary tuberculosis.
..... (duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Sputum
(Signed) A. A. Morrison, M. D.
Nov. 16, 1929 (Address) Buhl

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl, Idaho — Date of Burial 11-17 1929

20. Undertaker L. J. Johnson — Address Buhl Idaho

FORM V-S. No. 5-A—25 M-1-19

RECEIVED DEC 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 68468

Registered No.

1. PLACE OF DEATH

County of Valley

City of McCall

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. ..... St.)

2. FULL NAME Lee Francis Spencer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH Nov 14 1929 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer) Teamster

9. BIRTHPLACE (State or Country) Rose ferry Idaho

10. NAME OF FATHER Bert Spencer

11. BIRTHPLACE OF FATHER (State or Country) Georgetown Colorado Clearcreek County

12. MAIDEN NAME OF MOTHER Goldia I. Jewitt

13. BIRTHPLACE OF MOTHER (State or Country) Galt Missouri Grundy County

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed 11/6 1929 Stella Cann Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 14 1929 (Month) (Day) (Year)

161B

17. I HEREBY CERTIFY, That I attended deceased from Nov. 13 1929, to Nov 13 1929 that I last saw him alive on Nov. 13 1929, and that death occurred on the date stated above, at 8:30 M.

The CAUSE OF DEATH* was as follows:

Some obscure trouble or injury of (child) birth.

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

19 (Address) McCall Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL 19

20. UNDERTAKER

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. DEC 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 13
Primary Registration District No.
File No. 68469
Registered No.

1. PLACE OF DEATH
County of Valley
City of Cascade
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George C Camp.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7. AGE: Approximately Yrs. 70 years Mos. Ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): No one
(Address):

15. Filed 11/17 1929 Stella Cain Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 16 (Day) 1929 (Year) age

17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1929 to Nov 16 1929
that I last saw h. alive on Nov 16 1929
and that death occurred on the date stated above, at 8:45 P.M.
The CAUSE OF DEATH* was as follows:
Bronchitis
(Duration) 0 Yrs. 0 mos. 8 ds.
Contributory (Secondary) Nane
(Duration) yrs. mos. ds.
(Signed) Joseph C Ward M.D.
11/17 1929 (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Alpha Cemetery, DATE OF BURIAL: Nov 18 1929

20. UNDERTAKER: W. M. Bratney ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68470

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
Local Registrar's No. 16
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101

2. FULL NAME Samuel Walter Talbott.
(a) Residence. No. Weiser Route 4. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa A. Talbott.
6. DATE OF BIRTH (month, day and year) May 10 1864.
7. AGE 65 Years | Months 5 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) Greencastle. (State or country) Indiana.

PARENTS
10. NAME OF FATHER John Wessley Talbott.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Catherine Jones.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana.

14. Informant Rosa A. Talbott
(Address) Weiser, Ida Route 4
15. Filed Oct 13th, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 12 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Dropsy. died before medical assistance arrived
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Heart Trouble
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L. C. Northam Coroner
Oct 17, 1929 (Address) Weiser, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Stratton Colorado | Date of Burial 19
20. Undertaker L. C. Northam | Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1929

PLACE OF DEATH

County of Washington

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1010

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 68471

Local Registrar's No. 17

1010

2. FULL NAME Oscar Winfield Hauger

(a) Residence. No. 895 E Alder St. Portland Ore

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Wht

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Johanna Hauger

6. DATE OF BIRTH (month, day and year): Nov. 26. — 1875

7. AGE: Years 54 | Months 11 | Days 8 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Shoe Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Arkansas

PARENTS

10. NAME OF FATHER: Michael Hauger

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Mc Cormick

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Va.

14. Informant: Johanna Hauger

(Address) 895 E Alder st Portland Ore

15. Filed Nov 5th, 1929 F. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 4th, 19 29 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 19 29, to Nov 4, 19 29

that I last saw him alive on Nov 4, 19 29

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

Right.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C B Lamont, M. D.

Nov 4 '29, 19 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Dayton. Wash. | Date of Burial 19

20. Undertaker: L. L. Northam | Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

PLACE OF DEATH

County of Washington.

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1020

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68472

Local Registrar's No. 18

2. FULL NAME Hiram D. Mann.

(a) Residence. No. Emmett Idaho St. 24
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Divorced.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Divorced Nora. Mann

6. DATE OF BIRTH (month, day and year): Jan. 25 - 1894

7. AGE: Years 34 Months 10 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): apple Picker

(c) Name of employer: Mesa orchards

9. BIRTHPLACE (city or town) (State or country): Beloit. Kansas

PARENTS

10. NAME OF FATHER: Elias. A Mann.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Monroe co Ora. Ohio.

12. MAIDEN NAME OF MOTHER: Ora Duckenbush

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Green co. Indian

14. Informant: E A Mann
(Address) Emmett Idaho

15. Filed Nov 12, 1929 W R Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November. 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7 -, 1929, to Nov. 11, 1929 that I last saw him alive on Nov. 11 -, 1929 and that death occurred, on the date stated above, at 12. m.

The CAUSE OF DEATH* was as follows: Cerebrospinal. Meningitis Contagious Type.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Mesa Idaho

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) F A Schmitz, M. D.

Nov 11, 1929 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett. Idaho — Date of Burial: 11-13-1929

20. Undertaker: L. C. Northam — Address: Weiser. Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REGISTERED DEC 6 1929

PLACE OF DEATH

County of [redacted]

City of [redacted]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 76

Primary Registration District No. 1610

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 68473

Local Registrar's No. 19

2. FULL NAME Don Carlos Lyons

(a) Residence. No. 346 E Court St St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 2-1916

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
13.	5	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER A. R. Lyons

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Ida Anne Despain

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant John A. Lyons

(Address) Weiser Idaho

15. Filed Nov 26, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Shot accidentally while hunting by 22 Rifle bullet. in hands of boy Companion.

No Inquest (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. L. Northam Coroner M.D.

Nov 26, 1929 (Address) Weiser, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	11-26-1929

20. Undertaker	Address
L. L. Northam	Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68474

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1012
(No. 4th & Bullerfull St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

101 B

2. FULL NAME Jeppa Benson
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX SW
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Catherine Benson
6. DATE OF BIRTH (month, day and year) Apr. 1 - 1866
7. AGE Years 63 Months 7 Days 27 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Jeppa Benson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Hannah Hansen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Aaron Benson
(Address) Weiser Ida
15. Filed Nov 30th, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 27th (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 12th, 1929, to Nov 27th, 1929
that I last saw him alive on Nov 27th, 1929
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:
Pneumonia.
..... (duration) ..... yrs. ..... mos. 9 ds.
CONTRIBUTORY (Secondary) Toxemia
..... (duration) ..... yrs. ..... mos. 5 ds.
18. Where was disease contracted if not at place of death? ——
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) W. R. Hamilton, M. D.
Nov 27th, 1929 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Weston, Idaho — Date of Burial 11-30 1929
20. Undertaker L. C. Northam — Address Weiser Ida

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68475

Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. 21

PLACE OF DEATH

County of Washington
City of Weiser
(No. 204)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William E. Sanford

(a) Residence. No. 804 E Park St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Colt	married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Ida Sanford

6. DATE OF BIRTH (month, day and year) Oct. 25—

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64	1	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Lynn Nichols

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14. Informant Ida Sanford
(Address) Weiser Idaho

15. Filed Nov 30th, 1929 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 30 A.M. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows: Dropped dead while attending an Auction Sale

.....(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) .....
.....(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) L. C. Northam Coroner M. D.
Dec 2nd, 1929 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	12-2-1929
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 18 1929

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. POCATELLO GENERAL HOSPITAL) 36

(If death occurred in a hospital or institution, give its name instead of street and number.)

8476

DO NOT WRITE IN THIS SPACE

State File No. 68476

Local Registrar's No. 5710

2. FULL NAME CLARENCE E. MOCK

(a) Residence. No. ..... St. GLENNS FERRY, IDAHO.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of LELIA WILLIAMS

6. DATE OF BIRTH (month, day and year) APRIL 25, 1894

7. AGE	Years	Months	Days	If LESS than 1 day,
	35	6	29	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work SECTION

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer O. S. L. R. R.

9. BIRTHPLACE (city or town) (State or country) REXBURG, IDAHO.

PARENTS

10. NAME OF FATHER JOHN MOCK

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ARKANSAS

12. MAIDEN NAME OF MOTHER MARTHA MARTIN

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ILLINOIS

14. Informant MRS. LELIA MOCK

(Address) GLENNS FERRY, IDA.

15. Filed 11/26, 1929 J. M. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH NOV. (Month) 24, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-26, 1929, to 11-24, 1929

that I last saw h— alive on 11-24, 1929

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows: Tuberculous peritonitis

(duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Tuberculous kidney

(duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 11/2/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

11/26, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW CEMETERY	11/27 1929
20. Undertaker	**Address**
ARTHUR W. HALL	POCATELLO

RECEIVED DEC 19 1929

68477

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68477

Registration District No. 73
Primary Registration District No. 2170
Local Registrar's No. 229

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

(No. Spencer Hospital) 164
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kichige Tanigama

(a) Residence. No. Idaho Falls St. Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Yellow
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) August 13, 1856

7. AGE — Years: 73 | Months: 3 | Days: 24 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Restaurant Helper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Japan

PARENTS
10. NAME OF FATHER: Kichige Tanigama
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Japan
12. MAIDEN NAME OF MOTHER: Ashing Tanigama
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Japan

14. Informant: Frank Tanigama
(Address) Idaho Falls, Idaho

15. Filed 12/13, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec-4, 1929, to Dec-7, 1929
that I last saw him alive on Dec-7, 1929
and that death occurred, on the date stated above, at 9-45 P m.
The CAUSE OF DEATH* was as follows:
old age exhaustion
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
Dec 11, 1929 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Idaho — Date of Burial: Dec 9 1929
20. Undertaker: Jack A. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

68478

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68478

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
(No. 1607 Jefferson Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 345

44

2. FULL NAME Robert D. Hawley.
(a) Residence. No. 1607 Jefferson St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Widower.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Hawley.

6. DATE OF BIRTH (month, day and year): March 8th 1859

7. AGE: 70 Years, Months: 9, Days: 22. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Owner of Apartment House.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Cottage Grove, Oregon.

PARENTS

10. NAME OF FATHER: Ira Hawley.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York.
12. MAIDEN NAME OF MOTHER: Elvira Riley.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois.

14. Informant: Mrs. George R. Webster.
(Address) Boise, Idaho.

15. Filed 12-31, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 30th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Dec 1st~~ Oct 28, 1929, to Dec 30, 1929
that I last saw him alive on Dec 30, 1929
and that death occurred, on the date stated above, at 7:30 A.M.
The CAUSE OF DEATH* was as follows: Carcinoma of the Liver.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Nov 16 1929
Was there an autopsy? no
What test confirmed diagnosis? Pathologic Specimen
(Signed) Alfred Budge Jr., M. D.
12/31/29 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 1/2/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

68479

DO NOT WRITE IN THIS SPACE

State File No. 68479

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 64

Primary Registration District No. 2144

Local Registrar's No. .....

PLACE OF DEATH

County of Latah

City of Troy

(No. Troy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1000a

2. FULL NAME Alex Hilmer Oslund

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anna Marie Oslund

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	9	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn

PARENTS

10. NAME OF FATHER Henry Oslund

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Mary Pearson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Nathan Oslund

(Address) Troy Ida

15. Filed Dec 29 1929 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 17. 1929 to Dec 24 1929

that I last saw him alive on Dec 24 1929

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas. A. Thayer, M. D.

Dec 29 1929 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dry Creek Cem	Dec 29 1929

20. Undertaker	Address
John J. Pickard	Troy Ida

68480

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 68480

PLACE OF DEATH

County of Latah

City of Moscow

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

(No. .....)

Local Registrar's No. 58

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Kittie S. Washburn

74a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: M.E. Washburn

6 DATE OF BIRTH (month, day and year): June 18, 1858

7 AGE: Years 71 | Months 5 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Bloomfield Iowa

PARENTS

10 NAME OF FATHER: Thos. Gafton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ill.

12 MAIDEN NAME OF MOTHER: Eliza[redacted] Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: M.E. Washburn

(Address): Moscow, Idaho

15 Filed 12-5, 1929 W.H. Carithers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. 2, 1929 (Month) (Day) 19.... (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1929, to Dec 2, 1929, that I last saw her alive on Dec 2, 1929, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General arterial sclerosis

..... (duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical only.

(Signed) C. T. Gritman M. D.

12/4, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, ~~Cremation~~, or ~~Removal~~: Moscow

Date of Burial: 12/5/29 19

20. Undertaker: H. R. Short

Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stonelayer

RECEIVED JAN 13 1930

68481 Stonelayer

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68481

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1013

2. FULL NAME Thomas Rimmelspacher

(a) Residence. No. Peola St. Peola Wash.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Rimmelspacher

6. DATE OF BIRTH (month, day and year) May 25 1891

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	7	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Myself

9. BIRTHPLACE (city or town) (State or country) Peola Wash

PARENTS

10. NAME OF FATHER J. Rimmelspacher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER C. Goerg
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Otto Rimmelspacher
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23, 1929, to Dec 27, 1929
that I last saw living on Dec 27, 1929
and that death occurred, on the date stated above, at 11:15 P. m.
The CAUSE OF DEATH* was as follows:
Bilateral Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Peola Wash
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Diag
(Signed) A. Blodgett M. D.
1/6/30, 19 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	1/30 1929

20. Undertaker Vassar Mortuary Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

68482

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68482

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No.
Primary Registration District No. 96
(No. 306 - 5th Ave. 1009)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

47

2. FULL NAME Mrs Belle Mitchell

(a) Residence. No. 306 - 5th Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of M. Mitchell

6. DATE OF BIRTH (month, day and year) May 18 1867

7. AGE Years 62 Months 5 Days 16 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ky

PARENTS

10. NAME OF FATHER S. Riggs
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Geo F. Mitchell
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1929, to Dec 4, 1929
that I last saw her alive on Dec 4, 1929
and that death occurred, on the date stated above, at 1130 P m.
The CAUSE OF DEATH* was as follows:

Carcinoma R Breast

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? yes Date of July 27 1929
Was there an autopsy? no
What test confirmed diagnosis? microscopical examination
(Signed) E G Breast, M. D.
Dec 5, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho Date of Burial 12/7 1929

20. Undertaker Vassar Mortuary Inc Address Lewiston Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 15 1930

68483

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68483

PLACE OF DEATH

County of Custer
City of Leslie
Registration District No. 76
Primary Registration District No. 2153
Local Registrar's No. 126
(No. 49 B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME JOHN LEWIS

(a) Residence. No. (Usual place of abode) LESLIE IDAHO St.
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara Neilson Lewis

6. DATE OF BIRTH (month, day and year): Feb 4, 1846

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	11	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sawmill Operator
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Wales

PARENTS

10. NAME OF FATHER: Enoch Lewis
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales
12. MAIDEN NAME OF MOTHER: Ann Morgan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14. Informant: Lottie Walton
(Address): Bountiful, Utah

15. Filed 1/11, 1930 Rose Nowak Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/24/29, 19, to 12/25/29, 19
that I last saw him alive on 12/25/29, 19
and that death occurred, on the date stated above, at 3:00 A m.
The CAUSE OF DEATH* was as follows:

MYOCARDITIS; Chronic

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) NEPHRITIS; Chronic

(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical symptoms

(Signed) F. P. Richards, M. D.
12/26/29, 19 (Address) Mackay Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Bountiful Utah	

20. Undertaker	Address
Theo R Garnier	Mackay, Idaho

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68484

Local Registrar's No. 318

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. ....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Hattie Ellen Cowan

(a) Residence. No. 1610 North 15th St. 44B

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Robt. J. Cowan

6 DATE OF BIRTH (month, day and year) Dec. 25, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) (State or country) Genessee, Michigan

PARENTS

10 NAME OF FATHER Jacob Bedtelyon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Michigan

12 MAIDEN NAME OF MOTHER Mary J. Brigham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Michigan

14 Informant Mabel L Cowan

(Address) Boise, Idaho

15 Filed 12-9, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec (Month) 5 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June, 1927, to Dec 5, 1929, that I last saw her alive on Dec 4, 1929, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 10 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 6 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? ....

(Signed) R V Brack M. D.

Dec 7, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Morris Hill Cemetery — Date of Burial 12/8 1929

20. Undertaker Schreiber & McCann — Address Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68485

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hos)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 316

2. FULL NAME Nils Nelson

(a) Residence. No. Stay Rooms St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) ?

7 AGE: About 60 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Morrison Knudsen Co

9 BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10 NAME OF FATHER: Not obtainable
11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden
12 MAIDEN NAME OF MOTHER: Not obtainable
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: A. Schreiber
(Address): Boise

15 Filed 12-5, 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. (Month) 29 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1929, to Nov 29, 1929, that I last saw him alive on Nov 29, 1929, and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage from Basal skull fracture.
Fell down stairs
(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Accidental Injury
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Rooming House.
Did an operation precede death? yes Date of 11-28-29
Was there an autopsy? no
What test confirmed diagnosis? X-ray + Operation
(Signed) Neraly T. Nokes, M. D.
11-30, 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 12/5 1929

20. Undertaker: Schreiber & McCann
Address: Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 27 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68485

Dr. H.T. Nokes
Boise, Idaho
Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Nels Nelson who died Nov. 29,1929 at Boise, Idaho
Cause of death given as "Cerebral Hemorrhage from Basal Skull Fracture. Accidental Injury"

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH? IF AUTO PLEASE STATE WHERE ACCIDENTOCCURRED.

PLEASE ANSWER BELOW:

Patient fell down the stairs at the Stag Rooming House, Boise, Idaho.

Signed:

Herald T. Nokes

Herald T. Nokes, M. D.

by L.G.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68486

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 315

101B

2. FULL NAME Helen Wilma Jones

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 3, 1922

7. AGE

Years	Months	Days	If LESS than 1 day, ~~hrs.~~ or min.
7	1	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Boise
(State or country) Ida

PARENTS

10. NAME OF FATHER Hugh Jones
11. BIRTHPLACE OF FATHER (city or town) Ferron
(State or Country) Utah
12. MAIDEN NAME OF MOTHER May Whyman
13. BIRTHPLACE OF MOTHER (city or town) Adams
(State or Country) Nebr

14. Informant Hugh Jones
(Address) Meridian Ida

15. Filed 12-5, 1929 W. H. Rhodes
R. S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23, 1929, to Dec 2, 1929
that I last saw h..... alive on Dec 2, 1929
and that death occurred, on the date stated above, at 10:47 m.
The CAUSE OF DEATH* was as follows:
Pulmonary abscess
Secondary meningitis
(Pneumococcus) (duration) ..... yrs. ..... mos. 30 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Meridian
Did an operation precede death? Yes Date of Nov 23-29
Was there an autopsy? No
What test confirmed diagnosis? Clinical Lab reports
(Signed) James L. Stewart, M. D.
Dec 5, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or Removal: Meridian Ida
Date of Burial: 12-5 1929

20. Undertaker: B. W. Robison
Address: Meridian Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68487

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 314
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Klee
(a) Residence. No. 6 Miles West of Boise. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Divorced.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 68			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Don't Know.

PARENTS

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Pearl Allen.
(Address): Boise, Idaho.

15. Filed 12-4-1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. - 2 - 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30, 1929, to Dec 2, 1929
that I last saw h alive on Dec 1, 1929
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Embolus
Thrombus left Popliteal Vein
(duration) yrs. 1 mos. 1 ds.
CONTRIBUTORY (Secondary) Lawrence A. Kelley
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? Meridian Ida
Did an operation precede death? No Date of Dec 1929
Was there an autopsy? No.
What test confirmed diagnosis? Ob. Symptoms & Thrombus
(Signed) Andrew Alyworth, M. D.
12/2/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	12/4/29 19
20. Undertaker: McBratney	Address: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 8 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68488

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 313
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

133

2. FULL NAME Mrs. Harriett Virginia Longeteig.

(a) Residence. No. 2207 N. 13th street. St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Chris Longeteig.

6. DATE OF BIRTH (month, day and year): October 26th 1929

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
75	1	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Tipton, Iowa.

PARENTS

10. NAME OF FATHER: ------ Barryman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know.
12. MAIDEN NAME OF MOTHER: ------ Van Meter.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Don't Know.

14. Informant: Louis Longeteig.
(Address): Boise, Idaho.

15. Filed 12-2, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929, to Dec 1, 1929
that I last saw her alive on Dec 1, 1929
and that death occurred, on the date stated above, at 9 A.M. m.

The CAUSE OF DEATH* was as follows: Emfysema & Gall Bladder

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Gall Stones -

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Nov.
Did an operation precede death? yes Date of Nov 29/29
Was there an autopsy? no
What test confirmed diagnosis? Physical & Chemical findings

(Signed) Alfred Budge Jr - M. D.
12/2/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 12/3/29 19

20. Undertaker: Wm. McBratney.
Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68489

Local Registrar's No. 312

Registration District No. 3

Primary Registration District No. 1094

PLACE OF DEATH

County of Ada

City of Boise

(No. St Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Amanda Vermillion

(a) Residence. No. 2 Miles South of Boise St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Sylvester T. Vermillion

6. DATE OF BIRTH (month, day and year) Dec 29 1854

7. AGE	Years	Months	Days	If LESS than 1 day,
	74	11	2	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Frank McDaniels

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Margaret Wiseman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Sylvester T. Vermillion

(Address) Boise Idaho R 2 B 4

15. Filed 12-2, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 1 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1, 1929, to Dec 1, 19

that I last saw her alive on Nov 25, 19

and that death occurred, on the date stated above, at 12.10

The CAUSE OF DEATH* was as follows:

Chronic Cystitis &
Myocarditis

(duration) 10 yrs. 8 mos.

CONTRIBUTORY (Secondary) Vascular Heart dis & Myocarditis (duration) yrs. 8 mos.

18. Where was disease contracted if not at place of death? Canyon County

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. M. Creighton M.D.

Dec 2, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kamya Idaho — Date of Burial Dec 3, 19

20. Undertaker Summers & Kebo — Address Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68490

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 311

(No. 803 E. State Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME Laverne Mary Payne.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of ----------
(or) WIFE of

6. DATE OF BIRTH (month, day and year) November 30th 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	1	----------

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER John Pagac.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Austria.

12. MAIDEN NAME OF MOTHER Bessie French

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Buhl, Idaho.

14. Informant John Pagac.

(Address) Buhl, Idaho.

15. Filed 12-2, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30, 1929, to Dec 1, 1929

that I last saw her alive on Nov 30, 1929

and that death occurred, on the date stated above, at 10 29 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) O H Parker, M. D.

Dec 1, 1929 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	12/2/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68491

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 3
Primary Registration District No. 1004
Local Registrar's No. 310
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louise A. Childs

(a) Residence. No. 2103 State St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

161a L

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 30 - 1929

7. AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho.

PARENTS

10. NAME OF FATHER Richard M. W. Childs
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Louise A. Ashley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon

14. Informant R. M. W. Childs
(Address) 2103 State St Boise Idaho.

15. Filed 12-2, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30, 1929, to ....., 19.....
that I last saw her alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Premature birth - 6 months

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis

(Signed) W. A. Golsch, M. D.
....., 19.... (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Nov. 30 1929
20. Undertaker	Address
Summers & Kreps	Boise Ida

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68492

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 1004
(No. St Alphonsus Ho.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 309

2. FULL NAME Trans Oscar Fornell

(a) Residence. No. Eagle Room Grove St. 100a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year): March 12 1880

7 AGE: Years 49 | Months 8 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Morrison-Knudsen Co

9 BIRTHPLACE (city or town) (State or country): Smaland Sweden

PARENTS
10 NAME OF FATHER: John Fornell
11 BIRTHPLACE OF FATHER (city or town) (State or country): Smaland Sweden
12 MAIDEN NAME OF MOTHER: Susan Peterson
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Smaland, Sweden

14 Informant: Mrs. Nels Swanson State Road
(Address) Escanaba Mich Boise, Ida

15 Filed 12-2, 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. (Month) 24 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1929, to Nov 23, 1929, that I last saw him alive on Nov 23, 1929, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Acute Alcoholism
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Rooming House
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Findings
(Signed) W. A. Karlsch, M. D.
, 19 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 11/30 1929

20. Undertaker: Schreiber & McCann
Address: Boise Ia

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68493

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 103

PLACE OF DEATH

County of Ada.
City of Eagle.
(No. 2½ Miles North of Eagle.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Margaret Emily Chase.

(a) Residence. No. 2½ Miles North of Eagle St.
(Usual place of abode)
Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rush Chase.

6. DATE OF BIRTH (month, day and year) June 21st 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	6	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin.

PARENTS

10. NAME OF FATHER William Barr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin.
12. MAIDEN NAME OF MOTHER Sarah Davis.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Rush Chase.
(Address) Eagle, Idaho.

15. Filed 12-31, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH DEcember 28th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec ~~28~~ 27, 1929, to Dec 28, 1929
that I last saw her alive on Dec 27, 1929
and that death occurred, on the date stated above, at 1030a m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 24 ds.
CONTRIBUTORY (Secondary) Respiratory Paralysis
(duration) yrs. mos. 1hr
18. Where was disease contracted if not at place of death? Ada County
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. M. Braytan, M. D.
12/31/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 12/30/29 19

20. Undertaker: Wm. McBratney. — Address: Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 68494

PLACE OF DEATH

County of Ada

~~City of~~ near Star

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No.) 164

Local Registrar's No. 101

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Charlotte C Tuttle

(a) Residence. No. 2 Miles S.W. of Star St. 33 years in Ada Co

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 14 1837

7 AGE 92 Years | Months 6 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired ~~Housewife~~
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Ohio

PARENTS

10 NAME OF FATHER No Record

11 BIRTHPLACE OF FATHER (city or town) (State or country) American ~~No Record~~

12 MAIDEN NAME OF MOTHER No Record

13 BIRTHPLACE OF MOTHER (city or town) (State or country) American ~~No Record~~

14 Informant Warren Tuttle
(Address) Star Idaho

15 Filed 12-28, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec (Month) 25 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Many years, 19..., to Dec 25, 1929, that I last saw h. l alive on ..., 19..., and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Old Age — Natural Causes

(duration) Many yrs. — mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) Many yrs. — mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? l

What test confirmed diagnosis?

(Signed) C A Hall M. D.

Dec 26, 1929 (Address) Star Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Morris Hill Cemetery

Date of Burial: Dec 28 1929

20. Undertaker: Schreiber & McCann

Address: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68495

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 100

(No. U. S. Veterans' Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Francis M. Thompson

(a) Residence. No. White Bird, Idaho St.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. X yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6. DATE OF BIRTH (month, day and year) 3-3-1894

7. AGE	Years	Months	Days	If LESS than 1 day,
	35	9	20	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Joseph A. Thompson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oreg.

12. MAIDEN NAME OF MOTHER Elisabeth Ann Anspauch

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Me.

14. Informant M. Cornelius
(Address) U.S.Vet. Bureau, Boise, Idaho

15. Filed 12/24, 1929 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 23, 1929 (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 15, 1929, to December 23, 1929

that I last saw h im alive on December 23, 1929

and that death occurred, on the date stated above, at 8:20 A.M. m.

The CAUSE OF DEATH* was as follows:

Aortitis, Myocarditis with hypertrophy and hypertension.

nt 3

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bacteremia & Multiple pulmonary infarcts

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? xx

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Laboratory

(Signed) F.C. Smith, Reg. Med. Off., M. D.

12-25-29, 19 (Address) U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shipped Burial
White Bird, Idaho 12/24/29 19

20. Undertaker Wm. McBratney. Address Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 68496

PLACE OF DEATH

County of Ada

City of

CERTIFICATE OF DEATH 8

Registration District No.

Primary Registration District No. 2004

(No.)

Local Registrar's No. 99

R 31

(If death occurred in a hospital or institution, give its name instead instead of street and number)

2. FULL NAME Robert T Pim

(a) Residence. ~~No.~~ Ada County ~~St.~~ 8 Miles West of Boise
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. Bench How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Pauline C Pim Feb 3- 1864

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 65 | Months 10 | Days 19 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ontario Canada

PARENTS

10 NAME OF FATHER: David Pim

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ontario Canada

12 MAIDEN NAME OF MOTHER: Margaret Bouchart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Toronto Canada

14 Informant: Pauline C Pim

(Address) Boise, Ida

15 Filed 12/23, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. (Month) 22 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1929, to Dec 22, 1929 that I last saw him alive on Oct. 9, 1929 and that death occurred, on the date stated above, at 12 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Symptoms

(Signed) Fred A Pettinger, M. D.

12/23, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Joplin Cemetery

Date of Burial: 12/24 1929

20 Undertaker: Schreiber & McCann

Address: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68497

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 98

(No. 2 mi. W of Cole School 3½ mi. South 7th A
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John David Heater

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Josie A Heater

6. DATE OF BIRTH (month, day and year): Oct 8th 1851

7. AGE: Years 78 | Months 2 | Days 13 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer. Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Tiffin Ohio

PARENTS

10. NAME OF FATHER: Wm Heater
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know
12. MAIDEN NAME OF MOTHER: Elizabeth Decker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): .....

14. Informant: Mrs. Cora Schmelzer
(Address) Eagle Idaho

15. Filed 12/23, 1929 C W Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 21 (Month) (Day) 1929
Dec

17. I HEREBY CERTIFY, That I attended deceased from July, 1929 to Dec 21, 1929
that I last saw him alive on Dec 2, 1929
and that death occurred, on the date stated above, at 2.30 P m.
The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) C W Rhodes M. D.
Dec 24, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian, Ida.	12-23 1929
20. Undertaker: B. W. Robison	Address: Meridian Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68498

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 97

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

57 R

2. FULL NAME David Farmer

(a) Residence. No. 23rd and Smith St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 9 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Maria Farmer

6. DATE OF BIRTH (month, day and year): July 5 1862

7. AGE: Years 67 | Months 6 | Days 15 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer & Mining
(b) General nature of industry, business, or establishment in which employed (or employer): Farming Mine Managing
(c) Name of employer: Burns Mining & Milling Co.

9. BIRTHPLACE (city or town) (State or country): San Pete Valley Utah.

PARENTS

10. NAME OF FATHER: James Farmer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Leicester England.
12. MAIDEN NAME OF MOTHER: Sarah Broadbridge
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Barking Essex Co. England.

14. Informant: Harry Farmer
(Address): Boise Id

15. Filed 12-20, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1929, to Dec. 19, 1929
that I last saw him alive on Dec 19 9 P.M., 1929
and that death occurred, on the date stated above, at 2.45 a m.
The CAUSE OF DEATH* was as follows:
Diabetes

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. M. Holverson, M. D
Dec 20, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery | Date of Burial: Dec 22 1929

20. Undertaker: H S Mateer. Meridian Id | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 8 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68499

County of Ada.
City of Boise.
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 96
(No. Ada County Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Smith

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Christina E. Smith.

6. DATE OF BIRTH (month, day and year) January 6th 1855

7. AGE Years	Months	Days	If LESS than 1 day hrs. or min.
74	11	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10. NAME OF FATHER John Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Don't Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Walter Smith.
(Address) Emmett, Idaho.

15. Filed 12-16, 1929 W. N. Rhodes Registrar
R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 13th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Dec 13, 1929
that I last saw him alive on Dec 10, 1929
and that death occurred, on the date stated above, at 2 A.M. m.
The CAUSE OF DEATH* was as follows: Prostate Hypertrophy & Organic Heart Disease
(duration) 5 yrs. 3 mos. 13 ds.
CONTRIBUTORY (Secondary) Myocardial Degeneration (duration) 3 yrs. 3 mos. 19 ds.

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. M. Bradshaw M. D.
12/13/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett, Idaho.	12/15/29 19

20. Undertaker Wm. McBratney. Address Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No. ....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68500

Local Registrar's No. 95

74 B R

2. FULL NAME Josephine E Dow

(a) Residence. No. Near Collister Station St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Levi A. Dow.

6. DATE OF BIRTH (month, day and year) April 5, 1840

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
89	7	5	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winthrop Maine

PARENTS

10. NAME OF FATHER Calvin E Richardson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York State

12. MAIDEN NAME OF MOTHER Lucy Atkins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maine

14. Informant Richard Dodge.

(Address) Boise Idaho.

15. Filed 12-11, 1929 W. F. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29, 1929, to Dec 7, 1929

that I last saw h. alive on Dec 7, 1929

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis left.

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + senility

(duration) 20 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical findings

(Signed) Lyman F. West, M. D.

12-11, 1929 (Address) 413 Eastman Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pioneer Cemetery	Dec 12 1929

20. Undertaker	Address
Summers & Kreb	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

ECEIVED JAN 8 1930 DEPA TE OF IDAHO
BUR OF PUBLIC WELFARE
CER OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68501

Registration District No. 8

Primary Registration District No. 2804

Local Registrar's No. 94

(No. U. S. Veterans' Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH

County of Ada

City of Boise

2. FULL NAME Harry G. GARDENIER

(a) Residence. No. Reno, Nevada St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of xx

6. DATE OF BIRTH (month, day and year) 7-24-1872

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	4	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Calif.

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant M. Cornelius

(Address) U. S. Vet. Bureau, Boise, Idaho

15. Filed 12-9, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 19, 1929, to December 7, 1929

that I last saw h im alive on December 7, 1929

and that death occurred, on the date stated above, at 7:45 A.M. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Peritonitis, local, Pleurisy Fibro-purulent right chest.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Laboratory

(Signed) F.C.Smith, M. D.

12-9-29, 19 (Address) F.C.Smith, Reg.Med.Off. U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	12-10-29 19
20. Undertaker: Wm. McBratney	Address: Boise, Idaho

RECEIVED JAN 8 1930

PLACE OF DEATH

County of Ada

City of

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Budge

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68502

Local Registrar's No. 93

74a

2. FULL NAME George W. Drake

(a) Residence. No. 2 Miles South of Boise
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Nancy Emily Drake

6. DATE OF BIRTH (month, day and year): Jan. 23-1856

7. AGE: Years 73 Months 10 Days 9 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kentucky

PARENTS

10. NAME OF FATHER: Tillman P. Drake

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Nancy Roe

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn.

14. Informant: Mrs George W. Drake

(Address) R. #2 & Boise Idaho

15. Filed 12-3, 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2nd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19, 1929, to Dec 2, 1929

that I last saw him alive on Dec 2, 1929

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows: Cerberal Hemorrhage

(duration) yrs. mos. 12 ds

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) yrs. mos. ds

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Alfred Budge E., M. D.

Dec 3, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Dec 4 1929

20. Undertaker: Summers & Krebs — Address: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Collists

DO NOT WRITE IN THIS SPACE
State File No. 68503

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 331

R 164

2. FULL NAME Anna G. Corder
(a) Residence. No. 1122 Hays St St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 8-1847

7. AGE Years 82 Months 1 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER William Blaylock
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Jane Graham
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Irene Corder
(Address) 1122 Hays St Boise Ids

15. Filed 12-23, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1927, to Dec. 21, 1928
that I last saw her alive on Dec. 21, 1928
and that death occurred, on the date stated above, at 5:30 P. m.
The CAUSE OF DEATH* was as follows:
Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Geo Collister M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pioneer Cemetery
Date of Burial: Dec 24 1929

20. Undertaker: Summers & Krebs
Address: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68504

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 330

(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Virginia Ann Betts

(a) Residence. No. R.F.D. # 3 Nampa St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

119

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 25th 1929

7. AGE Years | Months 5 | Days 25 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa Idaho

PARENTS

10. NAME OF FATHER Archie Betts

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Minnie Grace Jones

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri.

14. Informant Archie Betts
(Address) R.F.D. # 3. Nampa Idaho.

15. Filed 12-21, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7:30 P.M. Dec. 19, 1929, to Dec. 20, 1929 that I last saw her alive on Dec. 20, 1929 and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Ileocolic intussusception

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Perforation of ileus from a small ulcer, probable (duration) a few hours ds.

18. Where was disease contracted if not at place of death? Near Nampa Idaho

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy findings

(Signed) Harmon Tremaine, M. D.

12-21, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Boise Valley Cemetery | Date of Burial: 12-22 1929

20. Undertaker: Mrs. Nina M. Talley | Address: Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68505

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 10011

Local Registrar's No. 329

(No.) (If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Sanderson Woodruff Ormsby.

(a) Residence. No. 1301 1/2 Hays St.
(Usual place of abode)
Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucy Ormsby

6. DATE OF BIRTH (month, day and year): Sept. 1 1874

7. AGE: Years 55 | Months 3 | Days 16 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): California

PARENTS

10. NAME OF FATHER: Oliver Ormsby
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Mrs Lucy Ormsby
(Address) 1301 1/2 Hays St Boise Idaho

15. Filed 12-19-29 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~December 25~~ Dec 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25, 1929, to Dec 17, 1929
that I last saw ~~him~~ alive on Dec 16, 1929
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(duration) 3 yrs. 22 ds.
CONTRIBUTORY (Secondary) General Oedema
& Heart Block (duration) yrs. 22 ds.

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) F. H. Beaston M. D.
Dec 18, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill cemetery	Dec 19 1929
20. Undertaker	Address
Summers & Treft	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68506

PLACE OF DEATH

County of .....

City of .....

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 328

(No. St. Luke's Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louis Elva Heath

(a) Residence. No. Emmett, Idaho, St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

117

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Heath

6. DATE OF BIRTH (month, day and year)

7. AGE Years 39 Months 3 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Transfer Bus.

(b) General nature of industry, business, or establishment in which employed (or employer) self

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Joplin, Mo.

PARENTS

10. NAME OF FATHER Frank Heath

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. Lou Heath.
(Address)

15. Filed 12-17, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1929, to Dec 16, 1929

that I last saw him alive on Dec 16, 1929

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis - Perforated.

Septic Peritonitis

Streptococcus (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Emmett Ida

Did an operation precede death? Yes Date of 12/13/29

Was there an autopsy? No

What test confirmed diagnosis? Ayer's Laboratory

(Signed) James K. Stewart, M. D.

....., 19.... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Emmett, Ida — Date of Burial 12-22 1929

20. Undertaker C. D. Buckman — Address Emmett

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68507

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2.
Primary Registration District No. 1004
Local Registrar's No. 327
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1929 P

2. FULL NAME Walter B. Sutton.

(a) Residence. No. Boise, Idaho R. #4. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) January 29th 1907.

7. AGE Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
22	10	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cambridge, Idaho.

PARENTS

10. NAME OF FATHER V. O. Sutton.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Fay Morey.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nevada.

14. Informant V. O. Sutton.
(Address) Boise, Idaho.

15. Filed 12-16-29 W. T. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 12th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1929, to Dec 12, 1929
that I last saw him alive on Dec 12, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Shock + internal injuries
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Auto accident
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) V. O. Brock, M. D.
12/13/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	12-14-29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68508

Local Registrar's No. 326

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48 B R

2. FULL NAME George Rose.

(a) Residence. No. 1510 N. 17th street. St.
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Don't Know.

6. DATE OF BIRTH (month, day and year) June 1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Meat Cutter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Illinois.
(State or country)

PARENTS

10. NAME OF FATHER Don't know.

11. BIRTHPLACE OF FATHER (city or town) " "
(State or Country)

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) "
(State or Country)

14. Informant A. C. Farley.

(Address) Boise, Idaho.

15. Filed 12-16 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 15th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14. 1929 to Dec 15 1929
that I last saw him alive on Dec 15 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Hypertrophied Arterial & Myocarditis

(duration) 5 yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? Boise Idaho

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Bradtan, M. D.

12/16/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	12/17/29 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68509

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 325

100 a

2. FULL NAME Benjamin Franklin Neal

(a) Residence. No. 1315 N. 14 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of May H. Neal

6. DATE OF BIRTH (month, day and year) Feb. 24, 1864.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	9	18.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lawyer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Peru Nebraska

PARENTS

10. NAME OF FATHER James Emery Neal.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio ~~Indiana~~
12. MAIDEN NAME OF MOTHER Mary Nisonchelser
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Mary H. Neal
(Address) 1315 N. 14 St Boise Idaho

15. Filed 12-14, 1929 W. H. Rhodes Registrar
R. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 1, 1929, to December 12, 1929
that I last saw him alive on December 12, 1929
and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Harold W Stone, M. D.
12/13, 1929 (Address) 317 Eastman Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Dec 14 1929
20. Undertaker	Address
Summers & Kirkham	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68510

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 3
Primary Registration District No. 1004
Local Registrar's No. 324
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lee Emery Eddefsen

(a) Residence. No. 1205 Leadville St.
(Usual place of abode)
Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct-24-1909

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	1	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hotel Employ
(b) General nature of industry, business, or establishment in which employed (or employer) Bristol Hotel
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Soda Springs Ida.

PARENTS

10. NAME OF FATHER James L. Eddefsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.
12. MAIDEN NAME OF MOTHER Lettie Thatcher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant James L. Eddefsen
(Address) 1205 Leadville St Boise Ida

15. Filed 12/3, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 12, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1929, to Dec. 12, 1929
that I last saw him alive on Dec. 11, 1929
and that death occurred, on the date stated above, at 8 25 A.M.
The CAUSE OF DEATH* was as follows:
Malignant Endocarditis
Ventricular heart failure
(duration) yrs. 1 to 2 mos. ds.
CONTRIBUTORY (Secondary) Cerebral Embolism
(duration) yrs. mos. 16 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical findings.
(Signed) H. E. Bellman M. D.
Dec. 13, 1929 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Dec. 14 1929
20. Undertaker: Summers & Kribs — Address: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68511

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 323

2. FULL NAME Theresa Haug Puckett

(a) Residence. No. 836 Warm Springs St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

44 B

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: W. H. Puckett

6 DATE OF BIRTH (month, day and year): June 2 - 1872

7 AGE: Years 57 | Months 6 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Idaho City, Ida

PARENTS
10 NAME OF FATHER: Nickolaus Haug
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Mary Garrecht
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: A. Schreiber
(Address) Boise

15 Filed 12-13 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 12 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1924, to Dec 12, 1929, that I last saw her alive on Dec 11, 1929, and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Coronary Thrombosis
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) A. B. Boock, M. D.
Dec 13, 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 12/15 1929

20. Undertaker: Schreiber & McCann
Address: Boise, Ida

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68512

Local Registrar's No. 332

Registration District No. 9
Primary Registration District No. 1004

PLACE OF DEATH

County of Ada.
City of Boise.
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vera Holmes.

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) December 5th 1929

7. AGE Years	Months	Days	If LESS than 1 day, ---------- hrs. or ---------- min.
0	0	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Lou Holmes.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Marie Graham.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know.

14. Informant George Ellis.
(Address) Payette, Idaho.

15. Filed 12-12, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 9th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ----------, 19---, to ----------, 19---
that I last saw h--- alive on ----------, 19---
and that death occurred, on the date stated above, at 2:35 P.M.
The CAUSE OF DEATH* was as follows:

Prematurity
Large ventral hernia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) A. J. Coats, M. D.
12/10/29, 19--- (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	12/10/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68513

Registration District No. 3
Primary Registration District No. 1004
Local Registrar's No. 321

PLACE OF DEATH

County of Ada.
City of Boise.
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Beryl Beth Peck.

(a) Residence. No. Vale, Oregon. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) September 12th 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	2	27	----------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ontario, Oregon.

PARENTS

10. NAME OF FATHER Charles W. Peck.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Ethel Case.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Neb.

14. Informant Mrs. C. W. Peck.
(Address) Vale, Oregon.

15. Filed 12-10 1929 W. A. Rhodes Registrar
R. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 9th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-5, 1929, to 12-9, 1929
that I last saw h[illegible] alive on 12-9, 1929
and that death occurred, on the date stated above, at 5 p m.
The CAUSE OF DEATH* was as follows: Encephalitis Lethargica

(duration) yrs. 1 mos. — ds.
CONTRIBUTORY (Secondary) Enteritis
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? Vale Ore.
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Spinal Fluid
(Signed) F W Allmond M. D.
12/10/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Roswell, Idaho.	12/11/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68514

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
(No.) Local Registrar's No. 320

(If death occurred in a hospital or institution give its name instead instead of street and number.)

2. FULL NAME Elizabeth Campbell

(a) Residence. No. 1317 W. Bannock St. 164
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Campbell

6 DATE OF BIRTH (month, day and year)

7 AGE Years about 92 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS
10 NAME OF FATHER James Burnside
11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland
12 MAIDEN NAME OF MOTHER Elizabeth
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant A. Campbell
(Address) Boise

15 Filed 12-9, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec (Month) 6th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 20th, 1928, to Dec 6th, 1929, that I last saw her alive on Dec 5th, 1929, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis - Heart lesions - senility -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) High blood pressure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Boeck M. D.
Dec 7th 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Morris Hill
Date of Burial 12-9 1929

20. Undertaker Schreiber & McCann
Address Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68515

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 319

(No. 1707 N. 9th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louis N. Franke.

(a) Residence. No. 1707 N. 9th St. 129
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 2nd 1866

7. AGE: Years 63, Months 6, Days 5. If LESS than 1 day, ~~hrs. or~~ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Mining.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Louisville, Ky.

PARENTS

10. NAME OF FATHER: Don't Know.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Don't Know.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany.

14. Informant: Mrs. L. N. Franke.
(Address) 1707 N. 9th st. Boise, Idaho.

15. Filed 12-9, 1929 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 7th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Oct 12, 1929, to Dec 7th, 1929

that I last saw him alive on , 19

and that death occurred, on the date stated above, at 7 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) DW pg & Endocarditis

(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Goodhart, M. D.

12/7/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery.

Date of Burial: 12/9/29 19

20. Undertaker: Wm. McBratney.

Address: Boise, Idaho.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68516

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 343

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

PLACE OF DEATH

County of Ada.
City of Boise.

2. FULL NAME Eng Ywe Gan

(a) Residence. No. 217 South 7th street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	Chinese.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 60			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chinese Store.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) China.

PARENTS

10. NAME OF FATHER Don't Know.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Pearl Allen.
(Address) Boise, Idaho.

15. Filed 12-31, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 27th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1929, to Dec. 30, 1929
that I last saw him alive on Dec 30, 1929
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fo Calvert, M. D.
12/31/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Chinese Cemetery.	12/30/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68517

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 342
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ida Tabor Canfield
(a) Residence. No. near Franklin School St.
(Usual place of abode)
Length of residence in city or town where death occurred. / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

129

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles E. Canfield
6. DATE OF BIRTH (month, day and year): Dec. 17-1869
7. AGE: Years: 59 Months: 11 Days: 28 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS
10. NAME OF FATHER: Thomas Tabor
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Mary Ann Cowan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: Charles E. Canfield
(Address) R # 4 Boise Idaho
15. Filed 12-31, 1929 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 14 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Dec 15, 1929
that I last saw her alive on Dec 15, 1929
and that death occurred, on the date stated above, at 3.50 P.M.
The CAUSE OF DEATH* was as follows:
Uremic Intestinal Nephritis
(duration) 3 yrs. mos. 14 d
CONTRIBUTORY (Secondary) Uraemic Poison
(duration) yrs. mos. 2 d
18. Where was disease contracted if not at place of death? Duluth Minn.
Did an operation precede death? No Date of —
Was there an autopsy? Yes What test confirmed diagnosis? Autopsy & Micro. exam
(Signed) H. Bratton M.D.
Dec 16, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLEN CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2 whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Dec 18 1929
20. Undertaker	Address
Simmons & Tribe	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68518

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus Hospital).
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 341

41

2. FULL NAME Margaret Bernease McGowan.
(a) Residence. No. ..... St. Burns Oregon
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Burns, I McGowan

6. DATE OF BIRTH (month, day and year): Mar 23-1905

7. AGE: Years 24, Months 9, Days 8. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Oregon

PARENTS
10. NAME OF FATHER: Claude Frizzell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Oregon
12. MAIDEN NAME OF MOTHER: Margaret Erickson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Oregon

14. Informant: Burns, I McGowan
(Address): Burns Oregon

15. Filed 12-31, 1929 W. H. Rhodes, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 31 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9, 1929, to Dec 31, 1929
that I last saw her alive on Dec 30, 1929
and that death occurred, on the date stated above, at 2:30 a m.
The CAUSE OF DEATH* was as follows:
Generalized septicaemia.
ō peritonitis,
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Incomplete abortion
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Boise.
Did an operation precede death? yes Date of 12-12-29.
Was there an autopsy? No.
What test confirmed diagnosis? Laboratory.
(Signed) Gerald T. Nokes, M. D.
12-31, 1929 (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Jan 1 1929

20. Undertaker: Summers & Krebs
Address: Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

130

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68519

CERTIFICATE OF DEATH

PLACE OF DEATH
County of ADA
City of BOISE

Registration District No. 2
Primary Registration District No. 1004
(No. ST. ALPHONSUS HOSPITAL)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 340

48a

2. FULL NAME DOLLIE E. REYNOLDS

(a) Residence. No. 511 1/2 MAIN St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Montie Clinton Reynolds

6 DATE OF BIRTH (month, day and year): Jan 18-1899

7 AGE: Years 30 | Months 11 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Near Ellensburg, Kittitass Co. Washington

PARENTS
10 NAME OF FATHER: George W. Shuey
11 BIRTHPLACE OF FATHER (city or town) (State or country): Mo.
12 MAIDEN NAME OF MOTHER: Rosie Fortney
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Town

14 Informant: Montie C. Reynolds.
(Address) Burgdorf Ida.

15 Filed 12-28 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December 20th 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 5-17-29, 19..., to 12-20-, 1929, that I last saw her alive on 12/20/29, 19..., and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:
Chronic Endocarditis
Chronic Myocarditis
Tertiary Syphilis.
(duration) 12 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Renal Infarct
(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Wassermann + Kahn
(Signed) Ernest E. Lanham M. D.
12/29, 1929 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 12/26 1929

20. Undertaker: Schreiber & McCann
Address: Boise, Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68520

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead instead of street and number.)
Local Registrar's No. 339

148c

2. FULL NAME Laura Edna Eberhart

(a) Residence. No. Star Ida. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Oswald E. Eberhart

6 DATE OF BIRTH (month, day and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
29	7	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cashier
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer C. C. Anderson

9 BIRTHPLACE (city or town) (State or country) Gering Nebraska.

PARENTS

10 NAME OF FATHER Stephen E. Kingery
11 BIRTHPLACE OF FATHER (city or town) (State or country) Illinois
12 MAIDEN NAME OF MOTHER Lottie May Wright
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Stephen E. Kingery
(Address) Star Ida.

15 Filed 12-28, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
12 (Month) 21 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 12/2/29, 1929, to 12/24, 1929, that I last saw her alive on 12/24, 19..., and that death occurred, on the date stated above, at 11 P., m.

The CAUSE OF DEATH* was as follows: Shock
Fracture of Ribs 1st to 9th Inclusive
Punctured Lung. Broken Hand
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Automobile accident at Boise Idaho
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Symp. & X Ray
(Signed) Fred. A. Pettingill, M. D.
12/27, 1929 (Address) Boise Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Star Cemetery	12/29 1929
20. Undertaker	Address
Schrebe & McCann	Boise

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68521

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 10,04
(No. St. Lukes)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 338

100a

2. FULL NAME Trilla Lurie Rose

(a) Residence. No. 1133 Michigan St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) April 7th 1928

7 AGE Years: Months 8 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boise, Ida

PARENTS
10 NAME OF FATHER Lou Rose
11 BIRTHPLACE OF FATHER (city or town) (State or country) Meridian
12 MAIDEN NAME OF MOTHER Goldy Sailor
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Salt Lake City Utah

14 Informant Lou Rose,
(Address) 1131 Michigan St. Boise

15 Filed 12-28, 1929 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. (Month) 27 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 9 Dec 26, 1929, to Dec 27, 1929, that I last saw her alive on Dec 27, 1929, and that death occurred, on the date stated above, at 9.05 P m.

The CAUSE OF DEATH* was as follows:
Double pneumonia bronchial
(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Foreign body in bronchus
(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec 26
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Tubar H Merrill, M. D.
Dec. 28, 1929 (Address) 520 Eastman Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 12/29 1929

20. Undertaker: Schreiber & McCann
Address: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68522

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 337

(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Mrs. Elizabeth J. Bailey.

(a) Residence. No. 2240 Division St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Dan Bailey

6. DATE OF BIRTH (month, day and year): January 15th 1861

7. AGE: Years 68, Months 11, Days 12. If LESS than 1 day, ~~hrs. or~~ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): England.

PARENTS

10. NAME OF FATHER: Charles May.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England.

12. MAIDEN NAME OF MOTHER: Grace. Bryant.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England.

14. Informant: Mrs. Edward McCoy.
(Address): Omaha, Neb.

15. Filed 12-28, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 27th 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1929, to Dec ~~28~~ 27, 1929 that I last saw her alive on Dec 27, 1929 and that death occurred, on the date stated above, at 5:12 P.M. m.

The CAUSE OF DEATH* was as follows: Mitral Stenosis & Nephritis

(duration) 6 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. One ds.

18. Where was disease contracted if not at place of death? Boise Idaho

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) T. N. Braxton, M. D.

12-28-29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 12/28/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68523

Local Registrar's No. 336

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

(No. 303 Fort Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Estella Budlong.

(a) Residence. No. 303 Fort St.
(Usual place of abode)
Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) June 5th 1851

7. AGE Years	Months	Days	If LESS than 1 day, ---------- hrs. or ---------- min.
78	6	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER George A. Budlong.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rhoad Island, N. Y.

12. MAIDEN NAME OF MOTHER Julia Bleckman.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mass.

14. Informant George Budlong.

(Address) Boise, Idaho.

15. Filed 12-28, 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 26th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-24, 1929, to 12-26, 1929, that I last saw h[illegible] alive on 12-26, 1929, and that death occurred, on the date stated above, at 11 A.M. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Lamon, M. D.

12/26/29, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 12/28/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68524

PLACE OF DEATH
County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 335

124

2. FULL NAME Anna Persicho.

(a) Residence. No. 1812-N-15th St Boise.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	widow

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of Thos C. Persicho

6. DATE OF BIRTH (month, day and year) Nov-2-1864

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	1	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House keeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Caleb Baldwin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont know.
12. MAIDEN NAME OF MOTHER Matilda Lindley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont know.

14. Informant Omar E Wright
(Address) Boise Idaho

15. Filed 12-26 1812-N-15th St, 19 29 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 18 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6th, 1929, to Dec 18th, 1929, that I last saw her alive on Dec 16th 1929 and that death occurred, on the date stated above, at 4-30 p.m.

The CAUSE OF DEATH was as follows:
Chronic Interstitial Nephritis.
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) High blood pressure
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) John Beeks, M. D.
Dec 26th 1929 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenleaf Cem	12/28 1929
20. Undertaker	Address
V Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68525

Local Registrar's No. 334

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

(No. 1811 N. 18th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Lena Spitzler.

(a) Residence. No. 1811 N. 18th St.
(Usual place of abode)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Spitzler.

6. DATE OF BIRTH (month, day and year) July 25th 1845.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	5	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Galla, Switzerland.

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland.

14. Informant Ernest Spitzler.
(Address) Boise, Idaho.

15. Filed 12-31 1929 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 25th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1929, to Dec. 24, 1929
that I last saw her alive on Dec. 24, 1929
and that death occurred, on the date stated above, at 6 A.M. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia + Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic asthma

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis? Physical Exam.

(Signed) Dr. J. M. Adams, M. D.
12/26/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	12/27/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68526

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
(No. Central Hotel, Boise, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 333

204

2. FULL NAME Bob Steele
(a) Residence. No. Boise, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Don't Know.

7. AGE: About 65 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Don't Know.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Don't Know.

PARENTS
10. NAME OF FATHER " "
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Wm. McBratney.
(Address) Boise, Idaho.

15. Filed 12-24, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
About December 17th 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, ~~That I attended deceased from~~ ~~, 19~~ ~~, 19~~ ~~that I last saw it alive on~~ ~~, 19~~ ~~and that~~ death occurred, on the date stated above, at not known m.

The CAUSE OF DEATH* was as follows:
Found Dead. Probably Chronic Heart Disease. Went to bed apparently well as usual and was found dead next afternoon.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Natural Cause.
No Inquest held.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Wm McBratney Coroner, ~~M. D.~~
12/21, 1929. (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 12/23/29. 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Budge.

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68527

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 332

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101B

2. FULL NAME Eleanor S. Glenn

(a) Residence. No. 401 Main St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June-12-1855

7. AGE: 74 Years; Months: 6; Days: 10; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: Daniel Gray
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Vernetta McClaren
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: Mrs Tom Brady
(Address) 401 Main Street Boise Idaho

15. Filed 12-24, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Dec 22, 1929
that I last saw her alive on Dec 22, 1929
and that death occurred, on the date stated above, at 4 10 9 m.
The CAUSE OF DEATH* was as follows:
Pneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Findings
(Signed) Alfred Budge Jr., M. D.
(Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Dec 24 1929

20. Undertaker: Summers & Krebs
Address: Boise Idaho

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68528

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. St Alphonsus)

Local Registrar's No. 349

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2 129

2. FULL NAME Hugh McGill

(a) Residence. No. 17th & River St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: wht

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1867

7 AGE Years 67 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Soldier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Not obtainable

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant A Schreiber
(Address) Boise, Ida

15 Filed 12-31, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec (Month) 24 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 12, 15 —, 1929, to 12-24, 1929, that I last saw h— alive on 12-23 —, 1929, and that death occurred, on the date stated above, at 12.15 A m.

The CAUSE OF DEATH* was as follows:

Nephritis Carditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acidosis, and Eurema

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. L. Frazier M. D.

12, 31, 1929 (Address) 513 E. Bldg Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial Jan 3 1930

20. Undertaker Schreiber & McCann Address Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68529

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 348

2. FULL NAME Sylvester M. Gant

(a) Residence. No. ..... St. 10 Miles South East of Boise
(Usual place of abode) (If nonresident give city or town and state)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Sout Knoll

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1866

7 AGE Years: about 63 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Oregon

PARENTS
10 NAME OF FATHER: Not obtainable
11 BIRTHPLACE OF FATHER (city or town) (State or country): " "
12 MAIDEN NAME OF MOTHER: " "
13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: M. Magnussen
(Address) Mayfield Idaho

15 Filed 12-31, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH 122

16 DATE OF DEATH: Dec (Month) 27 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1929, to Dec 27, 1929
that I last saw him alive on Dec 27, 1929,
and that death occurred, on the date stated above, at 5:20 P m.
The CAUSE OF DEATH was as follows:
Hepatic Cirrhosis
(duration) 2 yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Acites & Inanition
(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Ada County
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Aspiration
(Signed) P. N. Brayton, M. D.
Dec 30 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 12/30 1929

20. Undertaker: Schreiber & McCann
Address: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68530

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hos.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 347

99B

2. FULL NAME Harry Rattenbury

(a) Residence. No. ..... St. Idaho City Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year): About 70

7 AGE Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

Hold for Information

9 BIRTHPLACE (city or town) (State or country)

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) (State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant A. Schreiber
(Address) Boise Ida.

15 Filed 12-31, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec (Month) 27 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1929, to Dec 29, 1929, that I last saw him alive on Dec 28, 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Chronic Arthritis & Bronchitis
(duration) 5 yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis
(duration) ..... yrs. 1 mos. 5 ds.

18 Where was disease contracted if not at place of death? Boise County
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) T. N. Brayton, M. D.
Dec 30, 1929 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: St. John's Cemetery
Date of Burial: 12/31 1929

20. Undertaker: Schreiber & McCann
Address: Boise

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68531

PLACE OF DEATH
County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 346
(No. Iowa and Division street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Grace May.
(a) Residence. No. Iowa and Division St.
(Usual place of abode)
Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles May.

6. DATE OF BIRTH (month, day and year) July 31st 1831

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
98	4	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England.

PARENTS
10. NAME OF FATHER Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Mrs. Ed McCoy.
(Address) Omaha, Neb.

15. Filed 12-31, 1929 W. F. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 25th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ ~~, 19~~ ~~to~~ ~~, 19~~ ~~that I last saw him alive on~~ ~~, 19~~ ~~and that~~ death occurred, on the date stated above, at ~~m.~~

The CAUSE OF DEATH* was as follows:
Found Dead in Bed.
Senility.
Natural Cause.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) old age.
No Inquest.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) W. McBratney Coroner
12/26/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	12/28/29 19

20. Undertaker	Address
Wm. McBratney.	Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Dr Stewart or Nesk.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68532

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 344

(No. 2103 N. 15th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

46

2. FULL NAME Mrs. Freda Schneider.

(a) Residence. No. 2103 N. 15th St.
(Usual place of abode)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Schneider.

6. DATE OF BIRTH (month, day and year) December 10th 1866

7. AGE Years	Months	Days	If LESS than 1 day,
63	0	18	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fort Wayne, Ind.

PARENTS

10. NAME OF FATHER Fredrick Sinram.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Don't Know.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant John Schneider.

(Address) Boise, Idaho.

15. Filed 12-31, 1929 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 28th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25, 29, to Dec 28, 1929.

That I last saw her alive on Dec. 28, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovaries with metastasis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 25 29

Was there an autopsy? No. What test confirmed diagnosis? Operative findings

(Signed) L. T. Dent, M. D.

12/31/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	12/30/29 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 18 1929

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68533

PLACE OF DEATH

County of Ada

City of Meridian

Registration District No. 11

Primary Registration District No. 2003

Local Registrar's No. 12

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Turner J. Lucas

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Harriett Lucas

6. DATE OF BIRTH (month, day and year) Oct 3, 1848

7. AGE Years 81 Months 0 Days 24 (If LESS than 1 day, ... hrs. or ..... min.)

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mill employee

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Zanesville Ohio

PARENTS

10. NAME OF FATHER Sam Lucas

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Harriett Shields

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Zanesville Ohio

14. Informant Mrs Anna Chipman
(Address) Meridian Idaho

15. Filed Nov. 7, 1929 H F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 6th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25, 1929, to Nov 6, 1929 that I last saw him alive on Nov. 5th, 1929 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Brightis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H F Neal, M. D.

11-7, 1929 (Address) Meridian

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation,~~ or Removal Afton Iowa — Date of Burial 11-10 1929

20. Undertaker H. W. Robison — Address Meridian Ohio

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68534

Registration District No. 11

Primary Registration District No. 2003

Local Registrar's No. 13

PLACE OF DEATH

County of Ada

City of Meridian (No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucinda Keener

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Keener

6. DATE OF BIRTH (month, day and year) Dont Know

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dont Know Missouri

PARENTS

10. NAME OF FATHER Jim McCloud

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Guy C. Adams

(Address) Meridian Ada RFD

15. Filed 12-12, 1930 H F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 10th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/8-29, 19, to 12/10, 1929

that I last saw her alive on 12/9, 1929

and that death occurred, on the date stated above, at 8:05 P.M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H F Neal, M. D.

12-12, 1930 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fairview Cemetery	12-12 1929

20. Undertaker B. W. Robison Address Meridian Idaho

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68535

PLACE OF DEATH
County of Ada
City of Meridian

Registration District No. 11
Primary Registration District No. 2003
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14

129

2. FULL NAME Phoebe Miller

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 67 Years | Months: 1 | Days: | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife 14
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Polk Co Oreg.

PARENTS

10. NAME OF FATHER: Jackson Lowe
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Labisa Hillhoy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Oreg.

14. Informant: Edith Cobbe
(Address) Meridian Idaho

15. Filed 12-24, 1929 H F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18, 1929, to Dec 22, 1929
that I last saw her alive on Dec 20, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Chronic Parenchymatous Nephritis
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) H F Neal, M. D.
12-24, 1929 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho | Date of Burial: Dec 26 1929

20. Undertaker: W. S. Mateer | Address: Meridian

N. B.—Every item of information should be carefully supplied. AGE should be stated ..... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68536

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada

City of Kuna

Registration District No. 127

Primary Registration District No. 2202

(No. Kuna Idaho)

Local Registrar's No. 196

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Emma Jane Musselman

(a) Residence. No. Kuna, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: white

5 Single, Married, ~~Widowed, or Divorced~~ (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James R Musselman

6 DATE OF BIRTH (month, day and year): Feb. 21 - 1881

7 AGE: Years 48 | Months — | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lineville Iowa

PARENTS

10 NAME OF FATHER: John W Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Licking Co Ohio

12 MAIDEN NAME OF MOTHER: Sarah Inman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Miamma Co Ohio

14 Informant: Roy Musselman
(Address): Kuna

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 3 (Month) 3 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 2-9, 1929, to 3-3-, 1929, that I last saw her alive on 3-2-, 1929, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis with Aortic Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. F. Neal M. D.

3-4, 1929 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Kuna Ida

Date of Burial: 3-6-29 19

20. Undertaker: Wm McBratney

Address: Boise Idaho

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68537

Local Registrar's No. 195

PLACE OF DEATH

County of Ada

City of Kuna

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

43

2. FULL NAME Wm Irwin

(a) Residence. No. Kuna St.
(Usual place of abode)
Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 14th 1854

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	11	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mail messenger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER Wm Irwin

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER — Spence

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mrs. F. R. [illegible]
(Address) Nampa, Idaho

15. Filed 3-21, 1929 [illegible]
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-8, 1929, to 1-21, 1929
that I last saw him alive on 1-8, 1929
and that death occurred, on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:
Softening of the brain.

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 15 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) [illegible] M. D.
1-22, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	1-23 1929

20. Undertaker Wm D. Talley Address Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19 REC'D JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68538
Local Registrar's No. 194

1. PLACE OF DEATH
County of Ada
City of Rural
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James L. Booth

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widowed
6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)
7. AGE: 83 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): (Retired)
9. BIRTHPLACE (State or Country): Ill.
10. NAME OF Father: Mike - Booth
11. BIRTHPLACE OF FATHER (State or Country): unknown
12. MAIDEN NAME OF MOTHER: Baker
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G W Reynolds
(Address) Kuna Ida
15.
Filed 3-21 1929 Roy Musselman Local Registrar

MEDICAL CERTIFICATE OF DEATH 90

16. DATE OF DEATH: 2 (Month) 8 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 10 1928 to Feb-8 1929, that I last saw him alive on Feb-8 1929, and that death occurred on the date stated above, at 12:40 P.M.
The CAUSE OF DEATH* was as follows:
Mitral insufficiency
About (Duration) 5 yrs. — mos. — ds.
Contributory (Secondary)
Senero Drapsy (Duration) — yrs. 3 mos. — ds.
(Signed) F J Caleman M. D.
2-8 1929 (Address) Kuna, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kuna Cem — DATE OF BURIAL: 2-9 1929
20. UNDERTAKER: Fred K Pierson — ADDRESS: Nampa Ida

RECEIVED JAN 14 1930

PLACE OF DEATH

County of Ada

City of Kuna

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68539

Local Registrar's No. 197

100a

2. FULL NAME Lucile Mabel Bell

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) September 3rd 1928

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa Idaho

PARENTS

10. NAME OF FATHER John P. Bell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Gertrude Lewis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Mrs. J. P. Bell

(Address) Kuna, Idaho

15. Filed 3-14 1929 Roy Musselman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 4th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-19, 1929, to 3-4, 1929

that I last saw her alive on 3/3, 1929

and that death occurred, on the date stated above, at 2:22 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. F. Musel, M. D.

3/5, 1929 (Address) Meridian

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kuna Cemetery	3-5 1929

20. Undertaker	Address
Wm D. Talley	Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68540

PLACE OF DEATH
County of Ada
City of Kuna

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No. 198

(If death occurred in a hospital or institution, give its name instead of street and number.)

107

2. FULL NAME Rosalie Davidson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 12 March

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
6 mo 8 days	6		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho.

PARENTS

10. NAME OF FATHER Jesse A. Davidson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Blue Eye Missouri
12. MAIDEN NAME OF MOTHER Bertha Upleger
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Garden City Kansas.

14. Informant
(Address)

15. Filed 1-2-18, 1929. R. Musselman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 7. (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Oct 7, 1929
that I last saw her alive on Oct 7, 1929
and that death occurred, on the date stated above, at 5-55-A m.
The CAUSE OF DEATH* was as follows:

Spasmodic Croup.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) N. F. Linn M. D.
Oct 7, 1929 (Address) Meridian Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kuna Idaho	Oct 7-29
20. Undertaker	Address
E. W. Robison	Meridian Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68542

PLACE OF DEATH

County of Ada.
City of Kuna.
Registration District No.
Primary Registration District No.
Local Registrar's No. 200
(No. Kuna, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Mrs. Emma R. Yates.

(a) Residence. No. Kuna, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Divorced.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Yates.

6. DATE OF BIRTH (month, day and year) October 13th 1860

7. AGE Years	Months	Days	If LESS than 1 day
68	11	14	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER Barnett Mills.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois.
12. MAIDEN NAME OF MOTHER Martha Griffith.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa.

14. Informant Chester Yates.
(Address) Pendelton, Oregon.

15. Filed 12 28, 1929. Roy Musselman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH, October 29th 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ to ~~, 19~~ that I last saw him alive on ~~, 19~~ found dead at 8:15A. m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:
Had Chronic valvular Heart disease and had been in poor health for several months. (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Found dead in Bed. Natural Cause. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No Inquest held.
Did an operation precede death? — Date of —
Was there an autopsy? No.
What test confirmed diagnosis? —
(Signed) John Bratney, Coroner, M. D.
10/31/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kuna Cemetery — Date of Burial: 11/1/29 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68543

PLACE OF DEATH

County of Ada.
City of Kuna,

CERTIFICATE OF DEATH

Registration District No.
Primary Registration District No.
(No.)

Local Registrar's No. 201

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

65-A

2. FULL NAME John Herbert Harper.

(a) Residence. No. Kuna, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced
HUSBAND of Nettie Frances Harper.
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE	Years	Months	Days	If LESS than 1 day, or hrs. or min.
	44	5	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Civil Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer): Railroad Business.
(c) Name of employer: Southern Pacific Railroad Company.

9 BIRTHPLACE (city or town) (State or country): Colorada.

PARENTS

10 NAME OF FATHER: John Harper.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland.

12 MAIDEN NAME OF MOTHER: Katherine Morgan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wales.

14 Informant: Nettie Frances Harper
(Address): Kuna, Idaho.

15 Filed 1-13, 1930 — Roy Musselman, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. (Month) 18 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to Dec. 18, 1929, that I last saw him alive on Dec. 18, 1929, and that death occurred, on the date stated above, at 11:40 A m.

The CAUSE OF DEATH* was as follows:
Chronic Myeloin Leukemia with characteristic enormous enlargement of his spleen.
about
(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): None.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Washington D.C.
Did an operation precede death? No. Date of —
Was there an autopsy? No.
What test confirmed diagnosis? None except blood count.

(Signed) F. F. Coleman, M. D.
12-19, 1929 (Address) Kuna, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Kuna	
20. Undertaker: Fred K Robinson	Address: nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68544

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 57a1

(No. In hills 10 Miles So. of Poca. City.

(If death occurred in a hospital or institution, give its name instead of street and number.)

149 ds

2. **FULL NAME** Max Leanord Morris

(a) Residence. No. 555 South Grant Ave. Poca. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 31, ~~1929.~~

7. AGE	Years	Months	Days	If LESS than 1 day,
	15	5	10	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) At School

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) American Falls, Idaho.

PARENTS

10. NAME OF FATHER B. Thomas Morris

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Helen Neeley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant B. Thomas Morris

(Address) 555 South Grant Ave. Poca.

15. Filed 11/12, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 10, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Crushed Chest & Head
(Buried under load of Logs)
Accidental

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur W. Hall Coroner M. D.

Nov. 12, 1929 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	11/12/29. 19
20. Undertaker Arthur W. Hall	Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68545

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5702

(No. Imperial Cafe 118 N. 1st. Ave. Poca. 129

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George W. Fickel

(a) Residence. No. East Haliday Street St.
(Usual place of abode)

Length of residence in city or town where death occurred. 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 10, 1929.

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	6	3	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer) Not Employed

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER George W. Fickel

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Jane Underwood

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs. E. C. White

(Address) 206 N. 8th. Ave. Pocatello, Idaho.

15. Filed 11/16, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 13, 1929.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1929 to Aug 25, 1929

that I last saw him alive on Nov 13 - 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) agl

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) H. Saunders M. D.

11-15, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	11/15/29.

20. Undertaker Arthur V. Hall Address Pocatell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68546

Local Registrar's No. 5703

31

2. FULL NAME Charlie Mellin

(a) Residence. No. County Infirmary St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1857

7. AGE Years 72 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant E Hopkins

(Address) County Infirmary

15. Filed 11/13, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1927, to Nov 11, 1929

that I last saw him alive on Nov 11, 1929

and that death occurred, on the date stated above, at 9 — P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. R. Young, M. D.

11/13, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt. View Cemetery — Date of Burial 11-14 1929

20. Undertaker H. L. McKan. — Address Pocatello - Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68547

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 216/1
(No. RESIDENCE)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5704

49

2. FULL NAME WILLIAM WRIGHT

(a) Residence. No. 1020 EAST LANDER St.
(Usual place of abode)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of RUTH HOPEWELL

6. DATE OF BIRTH (month, day and year) MAY 29, 1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	5	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work LABORER
(b) General nature of industry, business, or establishment in which employed (or employer) JANITOR
(c) Name of employer POCA. CITY SCHOOLS

9. BIRTHPLACE (city or town) (State or country) ENGLAND

PARENTS

10. NAME OF FATHER ALFRED WRIGHT
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ENGLAND
12. MAIDEN NAME OF MOTHER MARY WRIGHT
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ENGLAND

14. Informant MRS. WM WRIGHT
(Address) 1020 - EAST LANDER, POCA. IDA.

15. Filed 11/19, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 15, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
Found dead in bed.
had pains in shoulders and arms
for three or four days.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? ... Date of ...
Was there an autopsy? ...
What test confirmed diagnosis? ...
(Signed) Arthur W Hall Coroner, M. D.
11/18, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW CEMETERY	11/18/29

20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 68548

Local Registrar's No. 5705

49

2. FULL NAME Capitola Johnson

(a) Residence. No. 1122 - North Hayes St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 6 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year)

7. AGE Years 67 Months ✓ Days ✓ If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER James Tilley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant James Edward Johnson
(Address) Pocatello - Idaho

15. Filed 11/19, 1929 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from None, 19..., to None, 19...

that I last saw her ~~alive on~~ Dead on arrival 19 11/16/29

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) C. P. Grosson, M. D.

11/18/, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pocatello - Idaho

Date of Burial 11-19 1929

20. Undertaker H. L. McHan

Address Poca. Ida.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68549

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5699
(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Anderson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb 27 - 1897

7. AGE: Years 632 | Months 8 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Baton Rouge Louisiana

PARENTS
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Ben Carothers
(Address) 630 N 5th Pocatello Idy

15. Filed 11/12, 1929 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Nov 8, 1929
that I last saw him alive on Nov 8, 1929
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows: Myocarditis & Nephritis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) J R Young, M. D.
11/12, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View | Date of Burial: Nov 10 1929

20. Undertaker: Schumacher Kressley | Address: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68551

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 5 8
Primary Registration District No. 2161
Local Registrar's No. 5700
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

148

2. FULL NAME Emma Lemon

(a) Residence. No. Ranch North of Poca. City St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wife of G. L. Lemon

6. DATE OF BIRTH (month, day and year) April 17, 1901

7. AGE	Years	Months	Days	If LESS than 1 day,
	28	6	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pine City, Minn.

PARENTS
10. NAME OF FATHER A. Ausmus
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Pauline Raider
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant G. L. Lemon
(Address) Tyhee, Idaho.

15. Filed 11/12, 1929 J. H. Gooney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 9, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5, 1929, to Nov 8, 1929, that I last saw h[illegible] alive on Nov 8, 1929, and that death occurred, on the date stated above, at 12 20 m.

The CAUSE OF DEATH* was as follows:
puerperal eclampsia

(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) manual delivery shock.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D C Ray, M. D.
11-12, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	11/12/29.

20. Undertaker Arthur W. Hall Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68552

PLACE OF DEATH
County of Bannock
City of Downey

Registration District No. 8 3
Primary Registration District No. 2160

Local Registrar's No. 1 10

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Burrup.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie C. Burrup.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65.	11	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) Farming
(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) West Weber Utah.

PARENTS

10. NAME OF FATHER James Burrup.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.

12. MAIDEN NAME OF MOTHER Mary Ann Bennett.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant John L Burrup
(Address) Downey Idaho.

15. Filed Dec. 10 – 1929 Mary C. Coffin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Nov. 18, 1929, to Nov. 18, 1929
that I last saw ~~him~~ alive on Nov. 18, 1929.
and that death occurred, on the date stated above, at 5 30 a. m.
The CAUSE OF DEATH* ~~was~~ as follows:
Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Laboratory tests.
(Signed) C A Kyle M. D.
Nov. 18 1929 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Grant Cemetery	
20. Undertaker None	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68553

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5206
(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John J. Kenney

(a) Residence. No. N. of City St. 126
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): April 28-1867

7. AGE: Years 62 | Months 6 | Days 19 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stationary Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): O.S.L. R.R.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): New York

PARENTS

10. NAME OF FATHER: Timothy Kenney
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Ann Gill
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Mrs John J. Kenney
(Address): Pocatello Idaho

15. Filed 11/20, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 17 (Month) (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16, 1929, to Nov 17, 1929
that I last saw him alive on Nov 17, 1929
and that death occurred, on the date stated above, at 7a m.
The CAUSE OF DEATH* was as follows:

General Peritonitis
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. W. Brothers, M. D.
11-20, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: Nov 20 1929
20. Undertaker: Schumacher & Beasley — Address: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68554

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161

Local Registrar's No. 5707

(No. RESIDENCE)
(If death occurred in a hospital or institution, give its name instead of street and number.)

11-2

2. FULL NAME VERNA MARIE THOMSON

(a) Residence. No. NORTH OF POCATELLO CITY St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	0	12	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: AT HOME
(b) General nature of industry, business, or establishment in which employed (or employer): INFANT
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): POCATELLO, IDA.

PARENTS

10. NAME OF FATHER: WILLIAM THOMSON
11. BIRTHPLACE OF FATHER (city or town) (State or Country): UTAH
12. MAIDEN NAME OF MOTHER: ROZETTA V. ANDERSON
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): UTAH

14. Informant: WILLIAM THOMSON
(Address): TYHEE, IDAHO.

15. Filed 11/14, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: NOV. (Month) 13, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to NOV 17, 1929
that I last saw her alive on NOV 17, 1929
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
acute catarrhal enteritis

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) D C Ray, M. D.
11-14, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MURRAY, UTAH.	ON ARRIVAL 19
20. Undertaker	Address
ARTHUR W. HALL	POCA. IDA.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68555

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. Lynn Bros Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 28 5708

2. FULL NAME Lillian Isabell Johnson

(a) Residence. No. 623 North 5th Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 5 mos. ✓ ds. ✓ How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Benjimen Johnson

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
42	42	9	9	✓

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) Cleveland Ohio
(State or country)

PARENTS
10. NAME OF FATHER John Stewart
11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14. Informant Benjimen Johnson
(Address) 623 N. 5th Ave

15. Filed 11/21, 1929 H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929, to Nov 20, 1929
that I last saw her alive on Nov 20, 1929
and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows:
Paralysis Shock
Cerebral Hemorrhage
(duration) yrs. 3 hours

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis Symptoms & Course

(Signed) H. L. Lynn M. D.
11-21-29 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello, Idaho	11-25-1929
20. Undertaker	Address
H. L. McHan	Poca. Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 18 1929

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 23

Primary Registration District No. 2161

(No. BANNOCK COUNTY INFIRMARY)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68556

Local Registrar's No. 5709

493

2. FULL NAME HENRY KETTLER

(a) Residence. No. POOR FARM St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) UNKNOWN

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
ABOUT 77			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work UNKNOWN

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9. BIRTHPLACE (city or town) (State or country) UNKNOWN

PARENTS

10. NAME OF FATHER UNKNOWN

11. BIRTHPLACE OF FATHER (city or town) (State or Country) UNKNOWN

12. MAIDEN NAME OF MOTHER UNKNOWN

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UNKNOWN

14. Informant COUNTY INFIRMARY

(Address) POCA. IDAHO.

15. Filed 12/2, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH NOV. 22, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1925, to Nov 22, 1929

that I last saw h[illegible] alive on Nov 22, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Young, M. D.

11/22, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
MOUNTAIN VIEW CEMETERY	11/23/29

20. Undertaker	Address
ARTHUR W. HALL	POCATELLO

RECEIVED DEC 18 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

DO NOT WRITE IN THIS SPACE

State File No. 68557

Local Registrar's No. 5711

1015

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Glenn G Golson

(a) Residence. No. 1431 - N. Arthur St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	✓	✓	✓

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Groceries - retail

(c) Name of employer O. P. Skaggs

9. BIRTHPLACE (city or town) Arkansas
(State or country)

PARENTS

10. NAME OF FATHER Sedney Gholson

11. BIRTHPLACE OF FATHER (city or town) Arkansas
(State or Country)

12. MAIDEN NAME OF MOTHER Pearl Clark

13. BIRTHPLACE OF MOTHER (city or town) Arkansas
(State or Country)

14. Informant Mrs. S. Gholson

(Address) 1431 - N. Arthur

15. Filed 12/26, 1929 J. M. Toomey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1929, to Nov. 23, 1929, that I last saw him alive on Nov. 23, 1929, and that death occurred, on the date stated above, at 8 40 a. m.

The CAUSE OF DEATH was as follows: Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) H. T. Howard, M. D.

11/26, 1929 (Address) Pocatello, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Pocatello, Idaho	
20. Undertaker	Address
H. L. McHan.	Poca. Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. Residence)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68558

Local Registrar's No. 573

2. FULL NAME Owen Conlon

(a) Residence. No. 936 South Main Street St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	65			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Boilermaker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant A. W. Hall Coroner

(Address) Pocatello Idaho

15. Filed 11/30, 1929 J. A. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 29, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) Arthur W. Hall Coroner M. D.

11/30, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Peoria, Illinois	On Arrival, 19...

20. Undertaker A. W. Hall Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68559

Local Registrar's No. 5712

141

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mildred M. Moran

(a) Residence. No. Daniels, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Moran

6. DATE OF BIRTH (month, day and year) Sept. 5, 1878

7. AGE	Years	Months	Days	If LESS than 1 day,
	51	2	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Leander Parquette
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Margaret Paradee
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant Mrs. C. D. Moore
(Address) 840 West Wyeth St. Boise. Idaho.

15. Filed 11/30, 1929. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 28, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22, 1929, to Nov 28, 1929
that I last saw her alive on Nov 27, 1929
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows: Myocarditis With Hypostasis.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of Nov 28
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John J. Rapp, M. D.
11/30/29 1929 (Address) Pocatello Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	11/30/29. 19
20. Undertaker Arthur W. Hall	Address Pocatello.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68560

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 5714

2. FULL NAME Forest Vasel Lee

(a) Residence. No. 535 S. Arthur St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	6	✓	✓	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho

PARENTS

10. NAME OF FATHER John W. Lee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hanson Fall River
12. MAIDEN NAME OF MOTHER Minnie Lovell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant John W. Lee
(Address) 535 So. Arthur

15. Filed 12/3, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929 to Nov 30, 1929
that I last saw him alive on Nov 30, 1929
and that death occurred, on the date stated above, at 7 a.m.
The CAUSE OF DEATH* was as follows:

Meningococcic meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Spinal fluid

(Signed) [illegible] M. D.
12-3, 1929. (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello, Idaho	Dec. 1 1929

20. Undertaker	Address
R. L. McKeen	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68561

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5715
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME William J. Hawkley

(a) Residence. No. 1040 North Ninth Ave. Poca. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ida. Coltrin

6. DATE OF BIRTH (month, day and year) Oct. 25, 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	1	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Public Schools
(c) Name of employer City of Poca.

9. BIRTHPLACE (city or town) (State or country) Portage, Utah.

PARENTS

10. NAME OF FATHER Joseph B. Hawkley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Jane Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant Mrs. William J. Hawkley
(Address) 1040 N. 9th. Ave. Poca. Idaho.

15. Filed 12/3, 1929. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 30, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1929, to Nov-30, 1929
that I last saw him alive on Nov 30, 1929
and that death occurred, on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency with Dilitation of Heart -
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Dellitation & Heart
(duration) yrs. 10 mos. ds.

18. Where was disease contracted if not at place of death? at Place of Death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical examination

(Signed) J. F. Miller, M. D.
12/2, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	12/3/29.
20. Undertaker A. W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 18 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. 403 Jefferson Ave.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68562

Local Registrar's No. 5716

100a

2. FULL NAME Annie Marie Thyberg

(a) Residence. No. 403 Jefferson Ave. Poca. St. Hyrum, Utah.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Fredrick Thyberg

6. DATE OF BIRTH (month, day and year) Dec. 10, 1929.

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	11	23	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Hanson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway

12. MAIDEN NAME OF MOTHER Marie Hanson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Mrs. Rudolph Thyberg

(Address) 403 Jefferson Ave. Poca. Idaho.

15. Filed 12-5, 1929 Dr. J. R. Young M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 3, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16, 19..., to Dec 3, 1929

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) Acute Rheumatism

(duration) ... yrs. ... mos. 1 hr.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D C Ray M. D.

12/4, 19... (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hyrum, Utah.	12/6/29. 19
20. Undertaker Arthur W. Hall	Address Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68563

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5717
(No. 1116 N. Hayes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME Ellen Louise Machel

(a) Residence. No. 1116 N. Hayes St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho

PARENTS

10. NAME OF FATHER Edward L Machel
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Margt F Hinton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Edward L. Machel
(Address) 1116 N. Hayes

15. Filed Dec 6, 1929 J. P. Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3, 1929, to Dec 6, 1929, that I last saw her alive on Dec 5, 1929 and that death occurred, on the date stated above, at 5 am m.

The CAUSE OF DEATH* was as follows:
Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical

(Signed) W. J. Howard, M. D.
12/6, 1929 (Address) Pocatello, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello, Idaho	Dec. 6 1929
20. Undertaker	Address
H. L. McHan	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68564

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. Lynn Bro's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 5718

1672

2. FULL NAME Jewel Virginia Kilbourne
(a) Residence. No. 708 N Arthur St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	5	✓	✓	✓ hrs. or ✓ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓ none
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS

10. NAME OF FATHER James B. Kilbourne
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Daisy Bradley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Mr. Daisy Kilbourne
(Address) 708 N. Arthur

15. Filed 12-7, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1929 to Dec 7, 1929
that I last saw him alive on Dec 7, 1929
and that death occurred, on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows:
Marasmus
(duration) yrs. 1 mos. 2 days

CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Pocatello
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) H. W. Lynn, M. D.
12/8/, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Pocatello Idaho	
20. Undertaker	Address
R. L. McKan	Poca. Ida.

Dr. Roberts

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68565

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 442 W. Fremont)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5719

24

2. FULL NAME Stanley Joseph Cleare Jr.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 16 1919

7. AGE: Years 10, Months 2, Days 21. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello Idaho

PARENTS
10. NAME OF FATHER: Stanley Joseph Cleare
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Salt Lake Utah
12. MAIDEN NAME OF MOTHER: Helen N. Tattener
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Palesburg Ill.

14. Informant: W. J. Mullen
(Address) Pocatello Ida.

15. Filed 12/8, 1929. J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) - 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-8, 1929, to 12-9, 1929
that I last saw him alive on 12-9, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Spinal meningitis
Epidemic -
..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) -
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? no Date of .....
Was there an autopsy? -
What test confirmed diagnosis? Laboratory
(Signed) [signature] M. D.
12/8, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mt View
Date of Burial: 12-8 1929

20. Undertaker: Schumacher & Beach
Address: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2-16

(No. Lynn Bros. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68566

Local Registrar's No. 5720

101A

2. FULL NAME William E. Newkirk

(a) Residence. No. 218 North Garfield Ave. St. Poca. Ida.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Husband of Bettie Cook

6. DATE OF BIRTH (month, day and year) June 15, 1865.

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	5	24	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mexico City, Missouri.

PARENTS

10. NAME OF FATHER Lafayette Newkirk

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico City, Missouri.

12. MAIDEN NAME OF MOTHER Nancy J. Doty

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa.

14. Informant Mrs. William E. Newkirk

(Address) 218 North Garfield Ave. Poca.

15. Filed 12/11, 1929. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 9, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1929, to Dec 9, 1929

that I last saw h alive on Dec 9, 1929

and that death occurred, on the date stated above, at 12:10 m.

The CAUSE OF DEATH* was as follows:

Tubar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) agd

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) M. Lynn M. D.

12-11, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mexico City, Missouri.	12/16/29.
20. Undertaker Arthur W. Hall	Address Pocatello

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68567

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161

Local Registrar's No. 5721

(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Rays Ledesma

(a) Residence. No. 816 North 1st. Ave. Poca. Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Mexican	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Husband of Fles Cordoba

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	71			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Mexico

PARENTS

10. NAME OF FATHER Fransico Cordola

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Mexico

12. MAIDEN NAME OF MOTHER Tomasita Cordola

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New Mexico

14. Informant Gabrial Ledesma
(Address) 816 North 1st. Ave. Poca. Idaho.

15. Filed 12/11, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 9, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6, 1929, to Dec 9, 1929
that I last saw him alive on Dec 8, 1929
and that death occurred, on the date stated above, at 11 a.m.
The CAUSE OF DEATH* was as follows: Myocarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical

(Signed) [signature] M. D.
12/11, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	12/11/29

20. Undertaker Arthur W. Hall — Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68568

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2-16-1
Local Registrar's No. 5722
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

24

2. FULL NAME Ernest Albert Cramton

(a) Residence. No. Mackay, Idaho. St. Mackay, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Husband of Addie May Hammond

6. DATE OF BIRTH (month, day and year) November 8, 1877

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	1	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Kansas

PARENTS

10. NAME OF FATHER: James Woods Cramton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Minnie J. Prater
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: Mrs. Ernest A. Cramton
(Address): Mackay, Idaho,

15. Filed 11/30, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 11, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1929 to Dec. 11, 1929.
that I last saw him alive on Dec. 11 1929.
and that death occurred, on the date stated above, at 8 05 P. m.
The CAUSE OF DEATH* was as follows:
Cerebrospinal fever (meningococcus meningitis)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Mackay, Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination spinal fluid
(Signed) A. N. Urghart, M. D.
12/12, 1929 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
San Luis Obispo Calif.	On Arrival
20. Undertaker Arthur W. Hall	Address Pocatello.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68569

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5723

(No. 428 North 9th. Ave. Poca. Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

11 B

2. FULL NAME Jay E. Aldous

(a) Residence. No. 428 N. 9th Ave. Poca. Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 14 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 3, 1928.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	4	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho.

PARENTS

10. NAME OF FATHER: Sidney E. Aldous

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ethel Aldous

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Downey, Idaho.

14. Informant: Sidney E. Aldous
(Address) 428 North 9th. Ave. Poca. Idaho.

15. Filed 12/11, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 11, 1929. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Dec 11, 1929 that I last saw him alive on Oct 30, 1929 and that death occurred, on the date stated above, at 8 45 a.m.

The CAUSE OF DEATH* was as follows:

[signature] (Intestional)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/11, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Downey, Idaho.

Date of Burial: 12/12/29.

20. Undertaker: Arthur W. Hall

Address: Pocatello

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68570

Local Registrar's No. 171

PLACE OF DEATH

County of Bannock
City of Chesterfield Ida
Registration District No. 84
Primary Registration District No. 2161
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Sidney Butterfield 7

(a) Residence. No. Chesterfield Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chesterfield Ida

PARENTS

10 NAME OF FATHER Leo Butterfield
11 BIRTHPLACE OF FATHER (city or town) (State or country) Utah
12 MAIDEN NAME OF MOTHER Ida May Call.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho

14 Informant Leo Butterfield
(Address) Chesterfield Ida

15 Filed Dec 19, 1929 Mrs G G Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec - 19 - 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:
Measles.
.....
.....
..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Family had measles
..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Had no doctor., M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Chesterfield	Dec-19 1929
20. Undertaker	Address
Had none.	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68571

PLACE OF DEATH
County of Bannock. Registration District No. 8
City of Lava Hot Springs Primary Registration District No. 2161
Local Registrar's No. 170
(No.) 196
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Willard Dewayn Bell

(a) Residence. No. Lava Hot Springs Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~: Alta Ardella Bell.

6. DATE OF BIRTH (month, day and year): Oct. 3, 1881.

7. AGE — Years: 48 | Months: 1 | Days: 23 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer (Haulingore)
(b) General nature of industry, business, or establishment in which employed (or employer): Teamster
(c) Name of employer: R. E. Wickham

9. BIRTHPLACE (city or town) (State or country): Weston Idaho.

PARENTS

10. NAME OF FATHER: Charles Morris Bell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): San Bardeno Cal.
12. MAIDEN NAME OF MOTHER: Jane Panting
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Astley England

14. Informant: Mary J. Bell
(Address): Lava Hot Springs

15. Filed Dec-11-, 1929. Mrs. G. G. Fitz, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov-26, 1929, to Nov-26, 1929
that I last saw him alive on Nov 26, 1929
and that death occurred, on the date stated above, at 330 P. m.

The CAUSE OF DEATH* was as follows: Accidental. Broken back & internal injuries. Due to fall from horseback.
(duration) yrs. mos. 2 hours

CONTRIBUTORY (Secondary): None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? no.
What test confirmed diagnosis? X-Ray.

(Signed) C. H. Rich, M. D.
Nov. 26, 1929 (Address) Lava Hot Springs.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 17 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

66571

Dr. C.A. Rich
Lava Hot Springs, Idaho
Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

- -

In reference to the death certificate of:

Willard Dewain Bell who died at Lava Hot Springs, Idaho on Nov. 26, 1929
Cause of death given as "Accidental--broken back and internal injuries."

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

" Accidental- broken back and internal injuries, due to fall from horse-back.

C. A. Rich M.D.

RECEIVED JAN 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68572

PLACE OF DEATH
County of Bannock
City of Arimo
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5724
(No. On Ranch at Arimo, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

171

2. FULL NAME Fred Swartz

(a) Residence. No. ____ St. Arimo, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day,
About	65			____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Ditch Rider
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant Arthur W. Hall
(Address) Coroner (Bannock County)

15. Filed 1/24, 1929. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 7, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to ____, 19__
that I last saw h__ alive on ____, 19__
and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:
Bled to Death
Knife Wound in Throat
Self Inflicted (Suicidal)
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

Arthur W. Hall.
(Signed) Coroner M. D.
12/24/29, 19__ (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	12/26/29.19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 16 1930

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. Pocatello General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68573

Local Registrar's No. 5725

119

2. FULL NAME Patti Ann Faust

(a) Residence. No. 218 South Johnson Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of Emile Faust

6. DATE OF BIRTH (month, day and year): July 7, 1897.

7. AGE: Years 32, Months 5, Days 8. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Lawrence, Kansas.

PARENTS

10. NAME OF FATHER: Allen S. Harris

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Martha Washington

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia.

14. Informant: Emile Faust

(Address) 218 So. Johnson Ave. Poca. Ida.

15. Filed 12/17, 1929. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. ~~XXX~~ 15, 1929.
Dec (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/8/29, 1929, to 12/15, 1929

that I last saw her alive on 12/15, 1929

and that death occurred, on the date stated above, at 12:05 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Stasis — Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation

G.B. [illegible] (duration) 12/11/29 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/11/29

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. C. Jowier, M. D.

12/17, 1929 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho. Date of Burial: 12/18/29.

20. Undertaker: Arthur W. Hall Address: Pocatello

RECEIVED MAY 14 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68573

Dr. H.C. Irwin
Pocatello, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Patti Ann Faust who died at Pocatello, Idaho on Dec. 15, 1929
Cause of death given as "Intestinal stasis toxaemia" "Operation for G.B. and Stomach."

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WASPERFORMED.

Pt. had had appendix removed several yrs ago

PLEASE ANSWER BELOW:

Death followed operation for chr. G.B. from start had abdominal distention that was not relieved. Was seen 3 x's in consultation by Dr. Thos. Mullen. She did not have a peritonitis - Death was certainly due to an intestinal Stasis - Toxaemia - I performed an ileostomy at end -

The above was stated on death certificate

H. C. Irwin

AUG 11 1930

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 16 1930

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68574

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5726

(No. 442 W. Bridger)

(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Augustus Clayton Hinckley

(a) Residence. No. 442 W. Bridger St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept 11. 1859

7. AGE: 70 Years, 3 Months, 8 Days. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired R. R. Mechanic Masker

(b) General nature of industry, business, or establishment in which employed (or employer): Supt Motive power

(c) Name of employer: O. S. L. at Poca

9. BIRTHPLACE (city or town) (State or country): Oswego N. Y.

PARENTS

10. NAME OF FATHER: Chas. Wheeler Hinckley

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Elizabeth Porter

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs. Frances Porter Hinckley
(Address) Pocatello, Idaho.

15. Filed Dec. 20, 1929 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 18 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/29, 1929, to 12/18, 1929 that I last saw him alive on 12-18, 1929 and that death occurred, on the date stated above, at 6.15 p.m.

The CAUSE OF DEATH* was as follows: Myocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. mos. 20 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/20, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Oakland Calif. Date of Burial: Dec 21 1929

20. Undertaker: McHan Undt Co. Address: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

J H Lynn

DO NOT WRITE IN THIS SPACE
State File No. 68575

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 429 N 11th)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5727

74A

2. FULL NAME Ruth Elizabeth Wybye

(a) Residence. No. 429 N 11th city St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 5th 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	8	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Patta
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant R O Henderson
(Address) Pocatello Idaho

15. Filed 1/27, 1929. J H Lynn Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1929, to Dec 19, 1929, that I last saw her alive on Dec 16, 1929, and that death occurred, on the date stated above, at 2:30 p m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam

(Signed) J. H. Lynn, M. D.
12/29/29 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	2 Jan 29
20. Undertaker	Address
Schumacher & Brady	City

RECEIVED JAN 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Lynn

DO NOT WRITE IN THIS SPACE
State File No. 68576

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 621 N. Hayes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5728

170

2. FULL NAME Robert Bilyeu
(a) Residence. No. 621 N. Hayes St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Mainly

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Oct 22-1886

7. AGE Years 43 Months 1 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Taxi Business
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS
10. NAME OF FATHER H. C. Bilyeu
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill
12. MAIDEN NAME OF MOTHER Vanakin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Lynn Bilyeu
(Address) Pocatello Idaho

15. Filed 12/27, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1929, to Dec 20, 1929
that I last saw him alive on Dec 20, 1929
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:
Gun shot wound of Brain
Suicide
(duration) 4 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) —
— (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? physical exam
(Signed) J. H. Lynn, M. D.
12/21/29 19 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View
Date of Burial Dec 24 1929

20. Undertaker Schumacher & Beasley
Address City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Jony

DO NOT WRITE IN THIS SPACE
State File No. 68579

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5732
(No. 322 W. Bridger)
(If death occurred in a hospital or institution, give its name instead of street and number.)

47

2. FULL NAME Louise Bawden

(a) Residence. No. 322 W. Bridger St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Aug 28-1850

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	3	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Schwindt Germany

PARENTS

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Louise Samuelson
(Address) 322 W Bridger

15. Filed 1/27, 1929 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/24, 1929, to 12/24, 1929
that I last saw her alive on 12/24, 1929
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Cancer of breast
(Carcinoma)
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? yes Date of —
Was there an autopsy? yes
What test confirmed diagnosis? Clinical
(Signed) J. H. Young, M. D.
1/27, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View	Dec 27 1929
20. Undertaker	Address
Schumacher & Beasley	City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68580

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Lynn Bros. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5733

90

2. **FULL NAME** John J. Moran

(a) Residence. No. Daniels, Idaho. St. Daniels, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Husband of Mildred Marquett

6. DATE OF BIRTH (month, day and year) March 5, 1882.

7. AGE	Years	Months	Days	If LESS than 1 day,
	47	9	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10. NAME OF FATHER Patrick Moran
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Mary McManus
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Marion Moran
(Address) Daniels, Idaho.

15. Filed 1/27, 1929. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 25, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1929, to Dec 25, 1929
that I last saw him alive on Dec 25, 1929
and that death occurred, on the date stated above, at 2:30 P m.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) agl
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? phy. Examination
(Signed) H. L. Lynn, M. D.
1/27/29 19 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	12/28/29. 19
20. Undertaker Arthur W. Hall	**Address** Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68581

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5734
160

2. FULL NAME Wm. Henry Bassett

(a) Residence. No. Lago - Idaho St. Lago Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of Mrs Wm Henry Bassett
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	0		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Salt Lake City Utah.

PARENTS

10. NAME OF FATHER Charles Henry Bassett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Mary ~~Ann~~ Knight

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Harry Bassett.
(Address)

15. Filed 1/28, 1929 J H Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/24, 1929, to 12-27, 1929
that I last saw ~~him~~ alive on 12-27, 1929
and that death occurred, on the date stated above, at 9 45 P. m.

The CAUSE OF DEATH* was as follows:
Embolus - following Auto accident
Injured, Head & Chest
accident Co Road - South of Pocatello 2dy.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) age ?
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Salt City.
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J H Young, M. D.
1/28, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lago Idaho,	12-31- 1929
20. Undertaker H. L. McHan	Address Poca. Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68582

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5729

131

2. FULL NAME Quest Smith
(a) Residence. No. 737 South Harrison Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 14, 1893.

7. AGE: Years 36, Months 10, Days 16. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Shopmen
(b) General nature of industry, business, or establishment in which employed (or employer): Section Foreman
(c) Name of employer: O. S. L. R. R.

9. BIRTHPLACE (city or town) (State or country): Bountiful, Utah.

PARENTS

10. NAME OF FATHER: Hyrum Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Salt Lake City, Utah.
12. MAIDEN NAME OF MOTHER: Sussie Garrett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. Pearl Jones
(Address) Pocatello, Idaho.

15. Filed 1/2, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 30, 1929. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/27, 1929, to 12/29, 1929
that I last saw him alive on 12/29, 1929
and that death occurred, on the date stated above, at midnight.
The CAUSE OF DEATH* was as follows:
In profession winner
(Kidneys)
Opes. appendix
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Operation appendix
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Pocatello?
Did an operation precede death? Yes Date of 12/27/29
Was there an autopsy? Yes
What test confirmed diagnosis? Usual
(Signed) [signature] M. D.
1/2/30, 19 (Address) Poca. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery
Date of Burial: 1/2/30 19

20. Undertaker: Arthur W. Hall
Address: Pocatello

HAMNER C. IRWIN, M. D.
CARLSON BUILDING
SUITE 311-12-13-14
POCATELLO, IDAHO

Mr Guest Smith relieved nicely following operation for acute appendix - Did not vomit, but twice - abdomen never distended - penis talus fair - Good pulse
Never passed much urine Catheterized twice - morning of 29th restless. did not void but 2 ounces in am. Cath - 1½ ozs in P.M.
Autopsy did not show any thing but small contracted hard kidneys - If suppression of urine was not cause of death - then I don't know what was

H. C. Irwin.
6/2/30.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68583

PLACE OF DEATH
County of Bear Lake
City of Paris

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 130

24

2. FULL NAME Miss ~~Ina~~ Ina Kulicke
(a) Residence. No. Paris Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 12-1920

7. AGE Years 9 Months 5 Days 18 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lanark Idaho

PARENTS

10. NAME OF FATHER Wm C. Kulicke
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vandenburg Germany
12. MAIDEN NAME OF MOTHER Rose Janssi
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Cantonberne Switzerland

14. Informant Fred Lewis
(Address) Paris Idaho

15. Filed 12-31, 1929 Mrs J. S. Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1929 to Dec. 29, 1929
that I last saw her alive on Dec. 29, 1929
and that death occurred, on the date stated above, at 4:15a m.
The CAUSE OF DEATH* was as follows:
Cerebro-Spinal Menengitis
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Muscular rigidity, hyperesthesia, Headache convulsions, delirium, Coma, High Fever
Did Opisthotonus
(Signed) Spencer H. Rich, M. D.
Dec 30 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Paris Idaho — Date of Burial 12-31 1929

20. Undertaker F. M. Williams — Address Ida. Montpelier

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68584

Registration District No.
Primary Registration District No.
Local Registrar's No. 129

PLACE OF DEATH
County of Bear Lake
City of Bloomington
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1013

2. FULL NAME Miss Marie Harriet Thompson

(a) Residence. No. Bloomington Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 17 yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 29, 1912

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	7	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bloomington Idaho

PARENTS

10. NAME OF FATHER Mr. Hyrum Thompson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bloomington Idaho
12. MAIDEN NAME OF MOTHER Cerissa Lessigor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Chesterfield Idaho

14. Informant Hyrum Thompson
(Address) Bloomington

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1929 to Dec. 21, 1929
that I last saw her alive on Dec 21, 1929
and that death occurred, on the date stated above, at 4.30 P. m.
The CAUSE OF DEATH* was as follows:
Bilateral Pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Dullness Increased vocal fremitus Pleural rub ~~Pleural pain~~ Pain in Chest
(Signed) Spencer H. Rich, M. D.
(Address) Paris Idaho
Dec 21, 1929

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bloomington Idaho — Date of Burial: Dec 24 1929

20. Undertaker: John Holme — Address: Bloomington Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68586

PLACE OF DEATH

County of Bear Lake
City of ~~Georgetown~~ Georgetown

Registration District No. 5
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

24

2. FULL NAME Idella Robinson
(a) Residence. No. Georgetown Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 9 - 1897

7. AGE: 32 Years | Months: 3 | Days: 23 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bennington Idaho

PARENTS

10. NAME OF FATHER: Frank Weaver
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill
12. MAIDEN NAME OF MOTHER: Sarah Fuelsay
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Boeing Idaho

14. Informant: Lewis Robinson
(Address): Georgetown Idaho

15. Filed 11/30/, 1929 H. H. King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30, 1929, to Nov 1, 1929
that I last saw her alive on Nov 1, 1929
and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Russell Tigert, M. D.
Nov 1, 1929 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Georgetown, Idaho | Date of Burial: Nov 1 1929

20. Undertaker: [illegible] Williams | Address: Montpelier Idaho

TION

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68587

PLACE OF DEATH
County of Georgetown Bear Lake
City of Georgetown
Registration District No. 52
Primary Registration District No. 2136
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

24

2. FULL NAME Howard Robinson
(a) Residence. No. Georgetown St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept 16 1926
7. AGE Years 3 Months 1 Days 19 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Conda Idaho

PARENTS
10. NAME OF FATHER Milton H Robinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montpelier Idaho
12. MAIDEN NAME OF MOTHER Idella Weaver
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bennington Idaho

14. Informant Milton H. Robinson
(Address) Georgetown Idaho
15. Filed 11/30, 1929 N H Kung Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov — 4 — 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 4, 1929 to Nov 4, 1929
that I last saw him alive on Nov 4, 1929
and that death occurred, on the date stated above, at 8 A m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
(duration) 4 hours yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Russell Tigert M. D.
Nov 4, 1929 (Address) Montpelier Idaho Conda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Georgetown Idaho
Date of Burial Nov 4 1929
20. Undertaker [illegible]
Address Montpelier Idaho

TION

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68588

PLACE OF DEATH
County of Bear Lake,
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136

Local Registrar's No.

(No. 47)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stephenson Hardinge

(a) Residence. No. Montpelier St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 1 1852

7. AGE Years	Months	Days	If LESS than 1 day,
77	10	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Civil Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lodi Wisconsin

PARENTS

10. NAME OF FATHER Capt. W. C. Hardinge

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Not Known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Mrs. Florence Mc Whirter
(Address) 150 N. Main Logan

15. Filed 11/30, 1929 A. H. King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9, 1929, to Nov 11, 1929
that I last saw alive on Nov 11, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Throat

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Guy Cudlipp, M. D.
11-14, 1929 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mont Rose Cem.	Nov 3 1929
20. Undertaker	Address
[illegible]	Montpelier Idaho

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68589

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

117

2. FULL NAME Hans Mary Dayton

(a) Residence. No. ..... Dingle St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, ~~or Divorced~~ (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 29 1924

7. AGE Years 5 Months 2 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Soda Springs
(State or country) Idaho

PARENTS

10. NAME OF FATHER H Freeman Dayton
11. BIRTHPLACE OF FATHER (city or town) Dingle
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Ida Perkins
13. BIRTHPLACE OF MOTHER (city or town) Chesterfield
(State or Country) Idaho

14. Informant H Freeman Dayton
(Address) Dingle Idaho

15. Filed 11/30, 1929 N N Reeg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18, 1929, to Nov 11, 1929
that I last saw her alive on Nov 11, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Pus - Appendicitis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Operations
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Leo F Lechley, M. D.
11-11, 1929 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Dingle Idaho
Date of Burial Nov 14 1929

20. Undertaker J M Williams
Address Montpelier Idaho

TIO

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68590

PLACE OF DEATH
County of Bear Lake
City of Dingle

Registration District No. 32
Primary Registration District No. 2132
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

71a

2. FULL NAME Anton Sorensen
(a) Residence. No. Dingle St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 3 1926

7. AGE 3 Years | Months 1 | Days 17 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dingle Idaho

PARENTS
10. NAME OF FATHER Andrew G Sorensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Sarah Neaver
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bennington Idaho

14. Informant Andrew G Sorensen
(Address) Dingle Idaho

15. Filed 11/30/1929 A N Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19, 1929, to Nov 20, 1929
that I last saw him alive on Nov 20, 1929
and that death occurred, on the date stated above, at 2:55 P.M.
The CAUSE OF DEATH* was as follows:
Meningitis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
12-12, 1929 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Dingle Idaho | Date of Burial Nov 21 1929
20. Undertaker [signature] | Address Montpelier Idaho

TION 1

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68591

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

145a

2. FULL NAME Elizabeth Ann Thompson

(a) Residence. No. Montpelier St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Thompson

6. DATE OF BIRTH (month, day and year) Aug 25 1892

7. AGE 37 Years | Months 3 | Days 2 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Robt Hallewell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Ann Holt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Thos Hartney
(Address) Mc Cammon Idaho

15. Filed 10/30, 1929 N Noteng Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929, to Nov 27, 1929
that I last saw her alive on Nov 27, 1929
and that death occurred, on the date stated above, at 11 A. m.
The CAUSE OF DEATH* was as follows:
Operation (Caesarian Section)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Child Birth
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Nov 20-29
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Mrs Ashley, M. D.
12-12, 1929 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho | Date of Burial Nov 30 1929

20. Undertaker F H Wilhams | Address Montpelier Idaho

TION

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68592

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

117

2. FULL NAME Joseph H. Hayes
(a) Residence. No. Georgetown Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 25 1910

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
19	10	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Georgetown
(State or country) Idaho

10. NAME OF FATHER Horace A. Hayes

11. BIRTHPLACE OF FATHER (city or town) Georgetown
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Alice Ann Roberts

13. BIRTHPLACE OF MOTHER (city or town) Bloomington
(State or Country) Idaho

14. Informant Horace A. Hayes
(Address) Georgetown Idaho

15. Filed 11/30/1929 H. N. King
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23, 1929, to Nov, 1929
that I last saw her alive on Nov 30, 1929
and that death occurred, on the date stated above, at 12 P m.
The CAUSE OF DEATH* was as follows:
Operation
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Appendicitis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Nov 23
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [illegible], M. D.
Nov 31, 1929 (Address) Honeyee

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Georgetown Idaho	Dec 4 1929

20. Undertaker	Address
[illegible]	Montpelier Idaho

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68593

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

161B

2. FULL NAME Thora C. Larsen
(a) Residence. No. Montpelier St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 8 1850

7. AGE 79 Years | Months 5 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS
10. NAME OF FATHER ? Johnhansen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway.
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant ~~Andrew~~ Oliver Larsen
(Address) Montpelier, Idaho

15. Filed 11/30, 1929 H. H. King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Nov 4, 1929
that I last saw her alive on Nov 4, 1929
and that death occurred, on the date stated above, at 8 a m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Pneumonia)
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Old age
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature], M. D.
11-11, 1929 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ogden Utah | Date of Burial Nov 7 1929

20. Undertaker [signature] | Address Montpelier Idaho

TION is very important. See instruction on back of certificate.

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68594

PLACE OF DEATH
County of Bear Lake
City of Montpelier, Idaho
Registration District No. 52
Primary Registration District No. 2136
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William H. Williams

(a) Residence. No. Nounan Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs.) mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 22 1877.

7. AGE: Years 52 | Months 8 | Days 8 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Paris Idaho

PARENTS

10. NAME OF FATHER: Noah H. Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Harriet C Lindsay Iowa. Wales
12. MAIDEN NAME OF MOTHER: Harriet C Lindsay
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa.

14. Informant: Mallard Williams
(Address): Nounan, Idaho.

15. Filed 1/31/, 1930. N A Reng Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 30 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——, 19—, to ——, 19—
that I last saw h— alive on ——, 19—
and that death occurred, on the date stated above, at —m.
The CAUSE OF DEATH* was as follows:
Dropped dead while seated in Car Preparatory to Driving out Hay Yard / Illness Due to Old Age
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W H Williams Coroner M. D.
Oct 31, 1929 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nounan, Idaho | Date of Burial: Nov 3 1929
20. Undertaker: W H Williams | Address: Montpelier Idaho

FORM V. S. No. 5-A-25M. 1-19

RECEIVED JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68595

Local Registrar's No.

Registration District No. 52

Primary Registration District No. 236

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geraldine Robinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: July (Month) 6 (Day) 1924 (Year)

7. AGE: 5 Yrs. 3 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Georgetown, Idaho

10. NAME OF Father: Roy H. Robinson

11. BIRTHPLACE OF FATHER (State or Country): Montpelier, Idaho

12. MAIDEN NAME OF MOTHER: Melba Weaver

13. BIRTHPLACE OF MOTHER (State or Country): Bennington, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy H. Robinson
(Address) Georgetown, Idaho

15. Filed 1/31/ 1930 A. Nelson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929. to Oct 19 1929., that I last saw her alive on Oct 19 1929., and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Russell Wright M. D.

Oct 19 1929 (Address) Soda Springs, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Georgetown Idaho

DATE OF BURIAL: Oct. 20 1929

20. UNDERTAKER: J. E. Williams

ADDRESS: Montpelier Idaho

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68596

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 5
Primary Registration District No. 3 3 C
Local Registrar's No.

(No.) 126
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harvey Peterson

(a) Residence. No. Montpelier 2dr St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or ~~WIFE of~~) Margaret Coolidge

6. DATE OF BIRTH (month, day and year) Dec 21 1904

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	9	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ovid Idaho

PARENTS
10. NAME OF FATHER John J. Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ovid Idaho
12. MAIDEN NAME OF MOTHER Hanna Svensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mountpark Idaho

14. Informant John J. Peterson
(Address) Ovid Idaho

15. Filed Oct 31, 1929 N Nelson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 20, 1929
that I last saw h~~im~~ alive on Oct 20, 1929
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows: General Peritonitis Ruptured Gallbladder

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Oct-1-29
Was there an autopsy? yes
What test confirmed diagnosis? Laparotomy
(Signed) L P Gardner M. D.
Oct 23, 1929 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ovid Idaho	Oct 23 1929
20. Undertaker	Address
T. M. Williams	Montpelier Ida

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2136

(No. ..... St.)

State File No. 68597

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wayne B. Rasmussen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word)

6. DATE OF BIRTH: May (Month) 24 (Day) 1929 (Year)

7. AGE: ..... Yrs. 4 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: James Rasmussen

11. BIRTHPLACE OF FATHER (State or Country): Mink Creek, Idaho

12. MAIDEN NAME OF MOTHER: Mary Emma Bakkdull

13. BIRTHPLACE OF MOTHER (State or Country): Georgetown, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Rasmussen

(Address) Montpelier Idaho

15. Filed 8/31 1929 H. H. King Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8 (Day) 1929 (Year) 1010

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1929, to Oct 8 1929, that I last saw him alive on Oct 8 1929; and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Moore M. D.

Oct 9 1929 (Address) by Lee Wilson Paris Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Georgetown, Idaho

DATE OF BURIAL: Oct. 9 1929

20. UNDERTAKER: F. M. Williams

ADDRESS: Montpelier, Idaho

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68598

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136

Local Registrar's No.

(No.) 24
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arline Robinson

(a) Residence. No. Georgetown St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 1 - 1925

7. AGE Years 3 Months 11 Days 22 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Georgetown
(State or country) Idaho

PARENTS

10. NAME OF FATHER Roy H Robinson
11. BIRTHPLACE OF FATHER (city or town) Montpelier
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Melba Weaver
13. BIRTHPLACE OF MOTHER (city or town) Bennington
(State or Country) Idaho

14. Informant Lewis Robinson
(Address) Georgetown, Idaho

15. Filed 10/31/1929 H H King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929, to Oct 23, 1929
that I last saw her alive on Oct 23, 1929
and that death occurred, on the date stated above, at 3:00 A. m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Russell Tigert, M. D.
Oct 23, 1929 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Georgetown Idaho
Date of Burial Oct 23 1929

20. Undertaker J. M. Wilbur
Address Montpelier Idaho

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68599

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 32
Primary Registration District No. 2136
Local Registrar's No.
(No. 24)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma C. Dunn

(a) Residence. No. Georgetown Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James Dunn.

6. DATE OF BIRTH (month, day and year) May 23 1884

7. AGE	Years	Months	Days	If LESS than 1 day,
	45	5	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Georgetown Idaho

PARENTS

10. NAME OF FATHER Seth Robinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Martha Holmes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant James C. Holmes
(Address) Montpelier Idaho

15. Filed 10/31/, 1929 N. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21, 1929, to Oct 31, 1929
that I last saw her alive on Oct. 30, 1929
and that death occurred, on the date stated above, at 1:30 A m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
(duration) yrs. mos. 10 ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Russell Taylor M. D.
Oct 31, 1929 (Address) Soda Springs, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Georgetown Idaho	Oct 31 1929

20. Undertaker [illegible] Address Montpelier Idaho

N. B. Every item of information should be carefully supplied. AGE should [illegible] NS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19. RECEIVED JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2136

(No. ..... St.)

State File No. 68600

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: June (Month) 18 (Day) 1867 (Year)

7. AGE: 62 Yrs. 3 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labour
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Salt Lake City Utah / Christopher Anderson

10. NAME OF Father: Christopher Anderson Oct 5 1929

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Johannah Roseng [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Jay Jones
(Address) Salt Lake City Utah

15. Filed 10/31 1929 [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

11B

16. DATE OF DEATH: Oct (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1929 to Oct 4 1929, that I last saw him alive on Oct 4 1929, and that death occurred on the date stated above, at 3:30 M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Oct 5 1929 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah
DATE OF BURIAL: Oct 5 1929

20. UNDERTAKER: [illegible]
ADDRESS: Montpelier Idaho

FORM V. S. No. 5-A-25M. 1-19. RECEIVED JAN 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2136

(No. ..... St.)

State File No. 68601

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donna Marie Simmons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: Dec (Month) 21 (Day) 1918 (Year)

7. AGE: 10 Yrs. 9 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Liberty - Idaho

10. NAME OF Father: James Simmons

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary E. Hymas

13. BIRTHPLACE OF MOTHER (State or Country): Liberty, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Simmons

(Address) Montpelier, Idaho

15. Filed 9/30/ 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

41

16. DATE OF DEATH: Sept (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1929 to Sept 24 1929, that I last saw her alive on Sept 24 1929 and that death occurred on the date stated above, at 8:30 M.

The CAUSE OF DEATH* was as follows:

Septicemia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Impacted foot

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

9-26 1929 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Liberty, Idaho

DATE OF BURIAL: Sept 27 1929

20. UNDERTAKER: [signature]

ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68602

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136
(No. ..... St.)

Local Registrar's No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Billy Van Brooks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: July (Month) 29 (Day) 1922 (Year)

7. AGE: 7 Yrs. 1 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Cokeville Wyo

10. NAME OF Father: Fred Brooks

11. BIRTHPLACE OF FATHER (State or Country): Colorado Springs Colo

12. MAIDEN NAME OF MOTHER: Margaret Vanderman

13. BIRTHPLACE OF MOTHER (State or Country): Green Bay, Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Margaret Brooks
(Address) Cokeville Wyo

15. 9/30/ 1929 N. N. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

41

16. DATE OF DEATH: Sept (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1929 to Sept 2 1929
that I last saw h alive on Sept 2 1929
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza Grippe
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ira E. Hyde M. D.
1929 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cokeville, Wyo. DATE OF BURIAL: 9/4 1929

20. UNDERTAKER: Fuellenwarth ADDRESS: Montpelier

s on back of certificate.

FORM V. S. No. 5-A-25M. 1-29

RECEIVED JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68603

Local Registrar's No.

Registration District No. 52

Primary Registration District No. 2136

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier.
If death occurs away from usual residence, give facts called for under special information.
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Poulsen.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow.
6. DATE OF BIRTH: Feb (Month) 4 (Day) 1848 (Year)
7. AGE: 81 Yrs. 6 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wales
10. NAME OF Father: David Humphreys.
11. BIRTHPLACE OF FATHER (State or Country): Wales
12. MAIDEN NAME OF MOTHER: (?) Matthews
13. BIRTHPLACE OF MOTHER (State or Country): Wales.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edgar Poulsen
(Address) Liberty, Idaho
15. Filed 8/31/29 A. Nielsen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 28 (Month) (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1929, to Aug 28 1929, that I last saw her alive on Aug 25 1929, and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
Cancer Stomach
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Old age
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Emil Nielsen M. D.
Aug 29 1929 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Liberty, Idaho — DATE OF BURIAL: Aug 30 1929
20. UNDERTAKER: Fitz Williams. — ADDRESS: Montpelier Idaho

Be careful, accurate and complete. Write plainly with pen and ink. Use no abbreviations except as specifically authorized. Answer EACH question. If none, or not known, so state. Do not refer to any question by number. Read carefully instructions printed on this certificate before writing. Any person who wilfully makes any false statement in this certificate shall be subject to the penalties prescribed for such offense. Prosecution and conviction of each violation of these provisions or of any of the following terms, so that it may be properly classified. Exact statement of OCCUPATION is necessary. Do not use the terms laborer, clerk, manufacturer, dealer, etc., without explanation. Instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 436

(No. ..... St.)

State File No. 68604

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lawrence Derricott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: March 25 1877 (Month) (Day) (Year)

7. AGE: 52 Yrs. 4 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF Father: James Hyman; Aug 29 1929

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Wm Sarah Evans

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Derricott
(Address) Liberty, Idaho

15. Filed 8/31/ 1929 N. H. King
Local Registrar

MEDICAL CERTIFICATE OF DEATH

140

16. DATE OF DEATH: Aug 20 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1929 to Aug 20 1929 that I last saw her alive on Aug 20 1929 and that death occurred on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Operation

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

(Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Liberty Idaho — DATE OF BURIAL: Aug 22 1929

20. UNDERTAKER: [illegible] — ADDRESS: Montpelier Ida

WRITE IS
N. B.—Every item of informa... fu... ed. AGE shoul... state CAUSE OF DEATH in plain terms, so that it may be properly classi... very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19 JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68605

Local Registrar's No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Johanna Andersen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6. DATE OF BIRTH: April 5 1842
(Month) (Day) (Year)

7. AGE: 87 Yrs. 4 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF Father: Jens Rasmussen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Got Larsen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Agnes Crozier
(Address) Paris Bear Lake Idaho

15. Filed 8/31/ 1929 N A Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1929 to Aug 5 1929, that I last saw h— alive on Aug 4 1929, and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Senile Dementia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Old age
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ernest Dudley M. D.
8-10 1929 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bloomington Idaho — DATE OF BURIAL: Aug 8 1929

20. UNDERTAKER: J. G. Williams — ADDRESS: Montpelier Idaho

o OCCUPATION is
o cert
ery important. See Instructions on back

FORM V. S. No. 5-A-25M. 1-19 RECEIVED JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2136

(No. ..... St.)

State File No. 68606

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Beulah Louisa Stevens Stewart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Sept (Month) 7 (Day) 1898 (Year)

7. AGE: 30 Yrs. 10 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Alexander Stevens

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Louisa C Krogue

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) M. L. Stevens Montpelier Idaho

15. Filed 8/31/ 1929 H H King Local Registrar

MEDICAL CERTIFICATE OF DEATH 129

16. DATE OF DEATH: Aug (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1929, to Aug 1 1929, that I last saw her alive on Aug 1 1929, and that death occurred on the date stated above, at 2:15 P M.

The CAUSE OF DEATH* was as follows:

Acute Exacerbation of a Chronic Diffuse Nephritis

..... (Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C O Moore M. D.

8/3 1929 (Address) Paris Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bloomington Idaho

DATE OF BURIAL: Aug 4 1929

20. UNDERTAKER: F M. Williams

ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH — Registration District No. 52
County of Bear Lake — Primary Registration District No. 2136
City of Montpelier — (No. ..... St.) (RUNZ)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mollie E Henry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

State File No. 68607
Local Registrar's No.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6. DATE OF BIRTH: Oct (Month) 16 (Day) 1862 (Year)

7. AGE: 66 Yrs. 9 Mos. 18 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF Father: John Ochsli

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Catherine Gurtlon

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Robert Henry
(Address): Bern Idaho

15. Filed 8/31/29 — H Williams, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1929 to Aug 3 1929
that I last saw h. alive on Aug 3 1929,
and that death occurred on the date stated above, at 1:30 P.M.
The CAUSE OF DEATH* was as follows:
Coma
Paralysis

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Old age
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Lee Dudley M. D.
8/4 1929 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bern Idaho — DATE OF BURIAL: Aug 5 1929

20. UNDERTAKER: H H Williams — ADDRESS: Montpelier Idaho

IMPORTANT.—THIS CERTIFICATE must be filled in by typewriter or with pen and ink and cannot be correctly registered unless all the items are properly answered or the reason for not answering is stated. If any item is unknown, state it as such. Do not leave any blanks except when directed to do so. If the information is not fully supplied, AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68608

Local Registrar's No.

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 736

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James S. Lindsay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Nov (Month) 2 (Day) 1858 (Year)

7. AGE: 70 Yrs. 9 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Utah

10. NAME OF Father: Edwin R. Lindsay

11. BIRTHPLACE OF FATHER (State or Country): Johnston Ontario Canada

12. MAIDEN NAME OF MOTHER: Tobith Cragan

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs James S Lindsay

(Address) Montpelier Idaho

15. Filed 8/31 1929 H H King Local Registrar

MEDICAL CERTIFICATE OF DEATH 44B

16. DATE OF DEATH: Aug (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1929 to Aug 4 1929, that I last saw him alive on Aug 4 1929, and that death occurred on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Gaeckle M. D.

8-5 1929 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dewyville Utah

DATE OF BURIAL: Aug 6 1929

20. UNDERTAKER: F. M. Williams

ADDRESS: Montpelier Idaho

...en of OCCUPATION is ... CAUSE OF DEATH in plain terms, so that it may be properly c... very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68609

Local Registrar's No.

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

Registration District No. 52

Primary Registration District No. 2135

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jack E Neilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Nov (Month) 13 (Day) 1925 (Year)

7. AGE: 3 Yrs. 8 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montpelier, Idaho

10. NAME OF Father: E Wall Neilson

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Mildred Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Montpelier Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Oswald Neilson
(Address): Montpelier, Idaho

15. Filed 7/31/29 N Hoskins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17 1929 to July 21 1929, that I last saw h[illegible] alive on July 21 1929, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Organic Heart Disease
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory Pneumonia
(Secondary)
(Duration) 0 yrs. 1 mos. 0 ds.

(Signed) O Wes Cooley M. D.
7/23/29 (Address) Montpelier Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho — DATE OF BURIAL: July 23 1929

20. UNDERTAKER: H A Wilson — ADDRESS: Montpelier Idaho

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19. RECEIVED JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bear Lake

City of Bennington

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2136

(No. ..... St.)

State File No. 68610

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Doris Jean Stephens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: Jan (Month) 3 (Day) 1926 (Year)

7. AGE: 3 Yrs. 6 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Bennington Idaho

10. NAME OF Father: Isaac Darwin Stephens

11. BIRTHPLACE OF FATHER (State or Country): Bennington Idaho

12. MAIDEN NAME OF MOTHER: Viola Carlson

13. BIRTHPLACE OF MOTHER (State or Country): Ovid Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Stephens
(Address) Bennington Idaho

15. Filed 7/31 1929 N. H. King
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 24 (Month) 1a (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1929 to July 23 1929, that I last saw her alive on July 23 1929, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

7/24 1929 (Signed) C. O. Moore M. D.
(Address) Paris Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bennington Idaho
DATE OF BURIAL: July 26 1929

20. UNDERTAKER: [illegible]
ADDRESS: [illegible] Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JAN 14 1930

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 57

Primary Registration District No. 2136

(No. ..... St.)

2. FULL NAME Hazen H. Musgrove

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 6861

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: April (Month) 24 (Day) 1863 (Year)

7. AGE: 66 Yrs. 3 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Railroad Engineer
(b) General nature of industry, business or establishment in which employed (or employer): (Retired 4 years)

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF Father: Musgrove

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs H H Musgrove
(Address) Montpelier Idaho

15. Filed 7/31/ 1929 H H King
Local Registrar

MEDICAL CERTIFICATE OF DEATH 1930

16. DATE OF DEATH: July (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1929 to July 3 1929
that I last saw h[illegible] alive on June 3 1929
and that death occurred on the date stated above, at 6 M.
The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

7/5 1929 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho | DATE OF BURIAL: July 7 1929

20. UNDERTAKER: [illegible] | ADDRESS: Montpelier Idaho

FORM V. S. No. 5-A-25M. 1-19. REC. JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 736

(No. ..... St.)

State File No. 68612

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rulon Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: March (Month) 31 (Day) 1903 (Year)

7. AGE: 26 Yrs. 3 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farm Laborer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ovid Idaho

10. NAME OF Father: Isaac Johnson

11. BIRTHPLACE OF FATHER (State or Country): Ovid Idaho

12. MAIDEN NAME OF MOTHER: Martha Hymas

13. BIRTHPLACE OF MOTHER (State or Country): Liberty, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isaac Johnson

(Address) Ovid Idaho

15. Filed 7/29/ 1929 N. N. King Local Registrar

MEDICAL CERTIFICATE OF DEATH 204

16. DATE OF DEATH: July (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19.., to ..... 19..., that I last saw h— alive on ..... 19..., and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows: Unknown Died during ~~the~~ while sleeping from natural causes.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

July 2 1929. (Address) Co Coroner Montpelier, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ovid Idaho

DATE OF BURIAL: July 5 1929

20. UNDERTAKER: [signature]

ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19. RECEIVED JAN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68613

Local Registrar's No.

1. PLACE OF DEATH

County of Bonneville

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2136

(No. ..... St.)

2. FULL NAME Ole Swenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Mar. (Month) 19 (Day) 1861 (Year)

7. AGE: 68 Yrs. 4 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Decorator
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Norway

10. NAME OF Father: Sven Larsen

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Johanna Jacobsen

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Swenson

(Address) Montpelier Idaho

15. Filed 7/31 1929 N. N. King Local Registrar

MEDICAL CERTIFICATE OF DEATH 75

16. DATE OF DEATH: July (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1929 to July 24 1929, that I last saw him alive on July 24 1929, and that death occurred on the date stated above, at 7 9 M.

The CAUSE OF DEATH*, was as follows:

Paralysis Agitans

(Duration) 4 yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Gaertner M. D.

July 1929 (Address) Montpelier Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho

DATE OF BURIAL: July 26 1929

20. UNDERTAKER: F. M. Williams

ADDRESS: Montpelier Idaho

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6861 4

PLACE OF DEATH
County of Bear Lake
City of Fish Haven

Registration District No. 55
Primary Registration District No. 2134
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

448

2. FULL NAME Niels Mortensen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 12 yrs. 8 mos. 12 ds. How long in U. S., if of foreign birth? 52 yrs. 5 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	10	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer none

9. BIRTHPLACE (city or town) (State or country) Simers Haven Sweden

PARENTS

10. NAME OF FATHER Peter Mortensons

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Margaret Hokensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Melvin Mortensen
(Address) Fish Haven Ida

15. Filed ....., 19.... Hannah J. Nelson Registrar
a. m.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1929, to Dec 27, 1929
that I last saw him alive on Dec 27, 1929
and that death occurred, on the date stated above, at 9P m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
.....
.....
(duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings

(Signed) C O Myers, M. D.
12/29, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68615

PLACE OF DEATH

County of Bear Lake
City of St Charles

Registration District No. 55
Primary Registration District No. 2134

Local Registrar's No. 8

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Martha Priscilla Clark

(a) Residence. No. St Charles Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Clark

6. DATE OF BIRTH (month, day and year) Feb 8 1846

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
83	9	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Thomas Barker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Thompson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Maurine Kelling
(Address)

15. Filed ....., 19.... H. J. Nelson Registrar
a. m.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21, 1929, to Nov 30, 1929
that I last saw h~~er~~ alive on Nov 21, 1929
and that death occurred, on the date stated above, at 11.35P m.

The CAUSE OF DEATH* was as follows:
Cardio-Vascular-Renal Disease

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical Findings

(Signed) C O Moore, M. D.
12/2, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65616

PLACE OF DEATH
County of Bear Lake
City of St. Charles

Registration District No. 55
Primary Registration District No. 2134

Local Registrar's No. 7

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frederick William Windley 1a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Carrie Windley

6. DATE OF BIRTH (month, day and year) May 30-1866

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	5	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Self

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER John Windley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Foster
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Ray G. Windley
(Address) St Charles Idaho

15. Filed ....., 19.... H. J. Nelson Registrar
a.m.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8, 1929 to Nov 16, 1929
that I last saw him alive on Nov 16, 1929
and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:
Typhoid Fever
(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical Findings
(Signed) C O Swan, M. D.
11/17, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Charles Idaho	Nov. 19. 1929

20. Undertaker J. A. Williams — Address Montpelier Idaho

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68617

PLACE OF DEATH

County of Idaho

City of St. Charles

Registration District No. 55

Primary Registration District No. 2134

Local Registrar's No. 6

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Hegwer 10

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 13 Years | Months: 10 | Days: 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) School Child

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER B. T. Hegwer

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Bertha Maud Hegwer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant B. T. Hegwer
(Address)

15. Filed ....., 19.... H. J. Nelson a.n. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28, 1929, to Nov 3, 1929

that I last saw her alive on Nov 3, 1929

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Post Diphtheric Paralysis

..... (duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Diphtheria

..... (duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) C O Moore, M. D.

11/16, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68618

PLACE OF DEATH
County of Bear Lake
City of St. Charles

Registration District No. 55
Primary Registration District No. 2134
Local Registrar's No. 4

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bennie Hegwer 13

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 24, 1926

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
2	10	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER B. T. Hegwer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....
12. MAIDEN NAME OF MOTHER Bertha Maud Carr
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant B. T. Hegwer
(Address) .....

15. Filed ....., 19.... H. J. Nelson Registrar
9:h

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25, 1929, to Oct 29, 1929
that I last saw him alive on Oct 25, 1929
and that death occurred, on the date stated above, at 1. P m.

The CAUSE OF DEATH* was as follows:
Mumps
..... (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) Pulmonary Embolism
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) C O Rogers, M. D.
11/16, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 13 '30

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68619

PLACE OF DEATH
County of Bear Lake
City of St Charles

Registration District No. 55
Primary Registration District No. 2134
Local Registrar's No. 3
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Amanda Green Arnell

HH

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of William H. Arnell

6. DATE OF BIRTH (month, day and year) Feb 24,

7. AGE Years	Months	Days	If LESS than 1 day,
57	~~Feb~~ 6	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Steven H. Green
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Adelia Hardy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maine

14. Informant Ann Arnell
(Address)

15. Filed ____, 19__. H. J. Nelson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 19, 1929, to Sept 21, 1929
that I last saw her alive on Sept 21, 1929
and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:
a Cancer
b
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Mitral Insuff.
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) C O Moore, M. D.
9/21, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19 RECEIVED JAN 9 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46.
Primary Registration District No. 2123.
File No. 68620
Registered No. 1 One

1. PLACE OF DEATH
County of Bannock.
City of Plummer Ida.
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth Francis Raymond.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 27th 1913. (Month) (Day) (Year)

7. AGE: 16 Yrs. 11 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Plummer. Idaho.

10. NAME OF FATHER: Leonard Francis Raymond.

11. BIRTHPLACE OF FATHER (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Mary Ellen Walker.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Eileen Morgan
(Address) Plummer. Ida.

15. Filed Dec. 20 1929 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

90

16. DATE OF DEATH: Dec 19th 1929. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18th 1929, to Dec 19th 1929, that I last saw him alive on Dec 18th "11 P.M." 1929, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart
34 Hours,
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Exposure
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Harrington M. D.
12/20 1929 (Address) Rivers, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Plummer, Ida — DATE OF BURIAL: Dec. 21 1929

20. UNDERTAKER: E. L. Jaques — ADDRESS: Plummer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 6 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
68621 10

1 PLACE OF DEATH
County Benewah State Idaho Registered No. 10
Township ____ or Village ____ or
City De Smet No. ____, St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anastasia Herbinaux Anna Bachel 31

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F.		Married

5a If married, widowed, or divorced
HUSBAND of Edward Herbinaux
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	36	3	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) De Smet, Idaho
(State or country)

PARENTS

10 NAME OF FATHER Ignace Timothy
11 BIRTHPLACE OF FATHER (City or town) Coeur d'Alene Reserve
(State or country)
12 MAIN NAME OF MOTHER Mary Cheedeye
13 BIRTHPLACE OF MOTHER (City or town) Coeur d'Alene Reserve
(State or country)

14 Informant Edward Herbinaux
(Address) De Smet, Idaho

15 Filed Jan 2, 1930 John Post REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1929, to Dec 31, 1929,
that I last saw her alive on Dec 29, 1929,
and that death occurred, on the date stated above, at 11.35 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) ____
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? at place of death
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. A. Nelson, M. D.
(Address) Tekoa Wash

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
De Smet, Idaho	Jan 2 1930
20 UNDERTAKER	ADDRESS
C. L. Schuberd	Tekoa, Wash.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

FORM V. S. No. 5-25 M. 1-16-13 1930

RECEIVED JAN 6 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 68622

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Benewah

City of Bensed 6 Mile East

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joan Cawrse

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Brown

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Sept 24 1929 (Month) (Day) (Year)

7. AGE ..... Yrs. 2 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Benewah Co Idaho

10. NAME OF FATHER Harold J. Cawrse

11. BIRTHPLACE OF FATHER (State or Country) Oakesdale wn

12. MAIDEN NAME OF MOTHER Helen May Curtis

13. BIRTHPLACE OF MOTHER (State or Country) Farmington wn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W E Curtis

(Address) Dumont Idaho

15. Filed Dec. 14 1929 John Post Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 205a

Dec, 13 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1929, to Oct 5 1929, that I last saw him alive on Oct 5 1929, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidently Smathered while Sleeping

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) C B Cleger M. D.

12-13 1929 (Address) Tekoa wn

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sanders Idaho

DATE OF BURIAL 12-15 1929

20. UNDERTAKER C. L. Schuelerind

ADDRESS Tekoa Wn

SYMS - YORK CO., PTRS. & SDRS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68623

PLACE OF DEATH

County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 43

164

2. FULL NAME Nellie LaCoutter

(a) Residence. No. St Maries St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If ~~married, widowed, or~~ divorced ~~HUSBAND of~~ (or) WIFE of Ed LaCoutter

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 84 | Months 8 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Quebeck Canada

PARENTS

10. NAME OF FATHER: Cota
11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....
12. MAIDEN NAME OF MOTHER .....
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant: Mrs Witzel
(Address) St Maries - 23 & St Maries

15. Filed Dec 31, 1929 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1930, to Dec 25, 1929
that I last saw her alive on Dec 25, 1929
and that death occurred, on the date stated above, at 6:10 A m.
The CAUSE OF DEATH* was as follows:
Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) D E Cornwall, M. D.
12-25, 1929 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Maries | Date of Burial: 12-27 1929

20. Undertaker: Geo E. Mitchell | Address: St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68624

PLACE OF DEATH

County of Benewah

City of St. Maries

Registration District No. 32

Primary Registration District No. 2049

Local Registrar's No. 42

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101B

2. FULL NAME Lila Maud White

(a) Residence. No. 346 — 15 St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Fred White

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 47 | Months 5 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ill.

PARENTS

10. NAME OF FATHER: Geo S Collins

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Barbra A Denney

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Daisy Kelly
(Address)

15. Filed Dec 31, 1929. Walter Boberg, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1929, to Dec 23, 1929

that I last saw her alive on Dec 22, 1929

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows: Pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary): Influenza

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

12-23, 1929 (Address) St. Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Maries, Ida | Date of Burial: 12-24 1929

20. Undertaker: Geo E. Mitchell | Address: St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68625

PLACE OF DEATH

County of Benewah

City of St. Maries

Registration District No. 32

Primary Registration District No. 2049

Local Registrar's No. 21

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David Sweet 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 57 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Forestry Works

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): unknown

PARENTS

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: John Smith
(Address) Chateolet Ida

15. Filed Dec 31, 1929 Walter Boberg
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-24, 1929, to 12-4, 1929

that I last saw him alive on 12-4, 1929

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G G Espe, M. D.

12/16, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Maries, Ida | Date of Burial: 12-18 1929

20. Undertaker: Geo E Mitchell | Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68626

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 40

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Fred Walsh

(a) Residence. No. St Maries St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years: 82 Months: Days: If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): unknown

PARENTS

10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): -
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Hospital Record
(Address)

15. Filed Dec 31, 1929 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 12, 1929, to December 14, 1929
that I last saw him alive on December 14, 1929
and that death occurred, on the date stated above, at 4:10 P m.
The CAUSE OF DEATH* was as follows:
Senility & arteriosclerosis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): arterio-sclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) D E Cornwall, M. D.
Dec 16, 1929 (Address) St. Maries Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Maries, Ida
Date of Burial: 12-17 1929

20. Undertaker: Geo E Mitchell
Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68627

PLACE OF DEATH
County of Benewah
City of Fernwood

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 39

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Briggs Kenoga
(a) Residence. No. Fernwood Idaho St. Fernwood, Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown
6. DATE OF BIRTH (month, day and year): July 14 - 1859
7. AGE: Years 70, Months 4, Days 25. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Terre Haute Ind

PARENTS
10. NAME OF FATHER: Thomas Briggs
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Margaret Havens
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Francis Kenoga
(Address)

15. Filed Dec 31, 1929 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 9 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 5, 1929, to Dec 9, 1929
that I last saw her alive on Dec 5, 1929
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows: Myocarditis
(duration) ? yrs. mos. ds.
CONTRIBUTORY (Secondary): Bronchial asthma - Pulmonary Emphysema (duration) ? yrs. mos. ds.
18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) D. Cornwall, M. D.
12/10, 1929 (Address) St Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Settle Wash. Date of Burial: 19
20. Undertaker: Geo E Mitchell Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68628

PLACE OF DEATH
County of Bingham
City of Sterling, Ida

Registration District No. 116
Primary Registration District No. 2195
Local Registrar's No. 32

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mabel La Marra Gravatt

(a) Residence. No. ..... St. Sterling Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 6 1927

7. AGE Years 2 Months 4 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Ida

PARENTS
10. NAME OF FATHER Frank C Gravatt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Davis City Iowa
12. MAIDEN NAME OF MOTHER Larena Fairchild
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lovell Wyo.

14. Informant Mrs. A. R. Berry
(Address) Glenns Ferry Ida

15. Filed 12/26, 1929 McMerkinney, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1929, to Dec. 26, 1929
that I last saw her alive on Dec. 26, 1929
and that death occurred, on the date stated above, at 2 am
The CAUSE OF DEATH* was as follows:
Measles
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Bronchial Pneumonia
(duration) yrs. mos. 12 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) M. C. McKinney M. D.
Dec. 26, 1929 (Address) Aberdeen, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Springfield, Ida
Date of Burial Dec. 27 1929

20. Undertaker Friends
Address

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68629

Registration District No. 127
Primary Registration District No. 2194
Local Registrar's No. 215

74a

PLACE OF DEATH

County of Bingham
City of Blackfoot
(No. Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William A. White

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred Since Mar. 24th 1929 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	3	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Albert White
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Cindrella Parr
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Baysinger, J.F.
(Address) Blackfoot, Idaho

15. Filed Dec 22 1929 Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24, 1929, to December 22 1929
that I last saw him alive on December 22, 1929
and that death occurred, on the date stated above, at 12:20 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Geo Williams, M. D.
Dec. 22nd, 1929 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Basin Idaho	
20. Undertaker E C Funk	Address Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68630

PLACE OF DEATH

County of Bingham

City of Blackfoot.

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 214

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Micheal John Beus,

(a) Residence. No. Moreland. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah E. Beus

6. DATE OF BIRTH (month, day and year): June 25, 1875

7. AGE: Years 54 | Months 5 | Days 20 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Ogedn, Utah

PARENTS

10. NAME OF FATHER: John Beus

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Margaret Justed

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy

14. Informant: J. Orval Beus
(Address): Moreland, Ida.

15. Filed Dec. 17, 1929 Mrs Walter E. Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) – 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2nd, 1929, to Dec 15, 1929 that I last saw him alive on Dec 15, 1929 and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Cancer of ear (Left) & Cervical region

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical Indicators

(Signed) J. O. Humphries M. D.

12-16, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moreland, Cemetary | Date of Burial: 12-18-29 19

20. Undertaker: Modern Mortuary, Blackfoot. | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68631

PLACE OF DEATH
County of Bingham
City of Moreland

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 213

84

2. FULL NAME Robert Adams
(a) Residence. No. Moreland Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliza Adams

6. DATE OF BIRTH (month, day and year): Dec 4 1875

7. AGE: Years 54, Months –, Days 5. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Self

9. BIRTHPLACE (city or town) (State or country): ~~Ohio~~ Richmond Utah

PARENTS

10. NAME OF FATHER: Samuel F. Adams
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Sarah Higgins Adams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Eliza Adams
(Address): Moreland Idaho

15. Filed Dec-11, 1929 Wm Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9, 1929, to Dec 9, 1929 that I last saw him alive on Dec 9, 1929 and that death occurred, on the date stated above, at 3:00 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

Type unknown (duration) 2 yrs. – mos. – ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of –
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) W W Beck, M. D.
12/10, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverside Thomas Cemetery
Date of Burial: Dec 12 1929

20. Undertaker: E J Peck
Address: Blackfoot Idaho

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68633

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 211

2. FULL NAME Martin M. O'Malley .90

(a) Residence. No. Southern Idaho Insane Asylum St.
(Usual place of abode)
Length of residence in city or town where death occurred. x yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6. DATE OF BIRTH (month, day and year): March 20 - 1860.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	8	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Not of Record
(c) Name of employer: Don't Know

9. BIRTHPLACE (city or town) (State or country): St Louis Mo,

PARENTS

10. NAME OF FATHER: Michael O'Malley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Bridget Dugan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Fred Hays
(Address): Blackfoot, Idaho

15. Filed Dec 2, 1929 Mon Walter E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 2nd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23rd, 1929, to Dec 2, 1929
that I last saw h~~is~~ alive on Dec. 2nd, 1929
and that death occurred, on the date stated above, at 6-10 P m.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Fred Hollingsworth, M. D.
Dec. 2nd, 1929 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Pocatello Idaho	Dec 4 1929

20. Undertaker: H. L. McKean. Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 8 1930 Current Complete November 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68634

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. Bingham County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 210

2. FULL NAME George Stone, Jr.
(a) Residence. No. 217 West Judicial St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1/24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Shoshone Ind. 3/4
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ---
6. DATE OF BIRTH (month, day and year)
7. AGE Years 22 Months -- Days -- If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ft. Hall Reservation

PARENTS
10. NAME OF FATHER George Stone, Sr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boise, Idaho
12. MAIDEN NAME OF MOTHER Mattie Camas
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Glenns Ferry, Idaho.

14. Informant George Stone, Sr.
(Address) Ft. Hall, Idaho.

15. Filed Dec. 22, 1929 Mon Walter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH
Treated by Dr. W. W. Beck
16. DATE OF DEATH Nov. 30, 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ___, 19___, to ___, 19___
that I last saw h___ alive on ___, 19___
and that death occurred, on the date stated above, at 1:30 A.m.
The CAUSE OF DEATH* was as follows:
Motorcycle accident: ran into a horse, causing a fracture at base of skull and broken neck.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Firth, Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examined by coroner
(Signed) Henry O. P. Heeler, M. D.
, 19___ (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Presbyterian Mission, Ft. Hall, Idaho, 12-6-29 Date of Burial 19
20. Undertaker Brown-Eldredge, Blackfoot, Ida. Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current Complete November 1929

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68635

PLACE OF DEATH

County of Ft. Hall Reservation, Idaho

City of

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 209

(No. ---)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Honeve Tommie Yapquadzo. 31

(a) Residence. No. ---- St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Bannock Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Yapquadzo

6. DATE OF BIRTH (month, day and year): 1880

7. AGE: Years 49 | Months -- | Days -- | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Sar6se-ver-it

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Ta-cav--ah

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Yapquadzo
(Address) Ft. Hall, Idaho

15. Filed Dec. 22, 1929 Mrs Walter E. Patrie, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 29, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1929, to Nov. 29, 1929, that I last saw her alive on Nov. 28, 1929, and that death occurred, on the date stated above, at 11:P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) 1 yrs. 2 mos. 27 ds.

CONTRIBUTORY (Secondary): ---

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? --

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry R. H. Leeler, M. D.

, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Butte Cemetery, Ft Hall, Idaho | Date of Burial: Dec. 7, 1929 19

20. Undertaker: Mc. Han, Pocatello, Idaho. | Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

Current Complete

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

November 1929

DO NOT WRITE IN THIS SPACE
State File No. 68636

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ft. Hall Reservation Idaho

City of

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 208

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Portneuf Charley

(a) Residence. No. ---- St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Tahmanzona

6. DATE OF BIRTH (month, day and year): 1857

7. AGE: Years 72; Months --; Days --; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Elmer Ellsworth.
(Address) Ft. Hall. Idaho.

15. Filed Dec. 22, 1929 Moss Walter E. Patrie, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 25, 1929 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Nov. 25, 29, 19
that I last saw him alive on Nov. 25, 1929, 19
and that death occurred, on the date stated above, at 5: P m.

The CAUSE OF DEATH* was as follows:

Nephritis- chronic

(duration) yrs. 4 mos. 25 ds.

CONTRIBUTORY (Secondary) ---

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Analysis of Ur

(Signed) Henry R. Hueler, M. D.

, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Prtneuf Cemetery. Ft. Hall Reservation. II-28

Date of Burial: 29 19

20. Undertaker: Brown & Eldredge, Blackfoot, Ida

Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current Complete Nov - 1929.

RECEIVED JAN 8 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68637

County of Ft. Hall Reservation
City of .....
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 207
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alvina Mink.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Shoshone Ind. 7/8
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6. DATE OF BIRTH (month, day and year) Nov. 29, 1927

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
I	II	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft. Hall Reservation

PARENTS

10. NAME OF FATHER Joseph Mink
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ft. Hall Reservation
12. MAIDEN NAME OF MOTHER Cora Pegoga
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lemhi Reservation

14. Informant Joseph Mink.
(Address) Ft. Hall, Idaho

15. Filed Dec. 22, 1929 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 26, 1929 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1929, to Nov. 26, 1929
that I last saw her alive on Nov. 26, 1929, 19..
and that death occurred, on the date stated above, at 9: A. m.
The CAUSE OF DEATH* was as follows:

Tubercular Meningitis.

..... (duration) ..... yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) ----

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? --
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Henry R. St. Lieler, M. D.
....., 19.. (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Portneuf Cemetery, Ft. Hall Reservation, II-29-29
Date of Burial 19..

20. Undertaker: Agency Carpenter, Ft. Hall, Ida
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930 Current Complete Oct. 1929.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68638

PLACE OF DEATH

County of Ft. Hall Reservation, Idaho.

City of

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 206

(No. Ft. Hall Agency Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Emma Tendoy.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Willie George.

6. DATE OF BIRTH (month, day and year): 1896

7. AGE: Years 33 | Months -- | Days --- | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lemhi Reservation

PARENTS

10. NAME OF FATHER: Hoorah Tendoy

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Lemhi Reservation

12. MAIDEN NAME OF MOTHER: Tse-ze-bone

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Montana

14. Informant: George Tendoy
(Address) Ft. Hall, Idaho.

15. Filed Dec. 22, 1929 Max Walter E. Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 20, 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1929, to Nov. 20, 1929
that I last saw her alive on Nov. 20, 1929, 19
and that death occurred, on the date stated above, at 7:30 P m.
The CAUSE OF DEATH* was as follows:

Apoplexy- Cerebral.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) Harry R. O'Keeler; M. D.

, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Presbyterian Mission Ft. Hall Reservation, Ida
Date of Burial: 11-25-29 19

20. Undertaker: Brown & Eldredge, Blackfoot, Ida
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Current

RECEIVED JAN 8 1930

Complete Oct. 1929.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 68639

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation, Idaho.

Registration District No. 121

Local Registrar's No. 205

City of

Primary Registration District No. 2194

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Hattie Thorpe Kiwonia

(a) Residence. No. ---- St. 129

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Bannock Ind. I/2

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kiwonia

6 DATE OF BIRTH (month, day and year): 1873

7 AGE: Years 56; Months --; Days --; If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia City, Mont.

PARENTS

10 NAME OF FATHER: George Thorpe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Teton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Joe Thorpe.

(Address) Blackfoot, Idaho.

15 Filed Dec. 22, 1929 Mrs Walter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 28, 1929 (Month) (Day) 19__ (Year)

~~Treated by Dr. Micthell & Beck~~

17 I HEREBY CERTIFY, That I attended deceased from Blackfoot, Idaho, 19__, to ___, 19__, that I last saw h___ alive on ___, 19__, and that death occurred, on the date stated above, at 1:55 P m.

The CAUSE OF DEATH* was as follows:

Nephritis- Chronic.

(duration) 1 yrs. 6 mos. ___ ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) ___ yrs. 6 mos. ___ ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Analysis of U

(Signed) Henry R. Wheeler, M. D.

___, 19__ (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Lincoln Creek Cemetery, Ft. Hall Reservation, 10-31-29

Date of Burial 19

20. Undertaker: ~~XXXXXXXXXX~~ Brown & Eldredge. Blackfoot

Address

Current

RECEIVED JAN 8 1930

Complete Oct. 1929.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68640

PLACE OF DEATH — CERTIFICATE OF DEATH

County of Ft. Hall Reservation Idaho — Registration District No. 121

City of ____ — Primary Registration District No. 2194

Local Registrar's No. 204

(No. ____)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Dick Lewis.

31

(a) Residence. No. --- St. ____

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Bannock Ind. 4/4	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jennette James

6 DATE OF BIRTH (month, day and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
	51	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): ____
(c) Name of employer: ____

9 BIRTHPLACE (city or town) (State or country) Rock Creek, Idaho.

PARENTS

10 NAME OF FATHER Rock Creek Jim.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Susie Tom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rock Creek, Idaho.

14 Informant Maggie Tyboats.
(Address) Ft. Hall. Idaho.

15 Filed Dec. 22, 1929 Walter E. Petrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 3. 1929
(Month) (Day) 19 (Year)

No Doctor attending

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____, that I last saw h____ alive on ____, 19____, and that death occurred, on the date stated above, at 6: P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) ____ yrs. 3 mos. ____ ds.

CONTRIBUTORY (Secondary) ---

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? ____

(Signed) Henry H. Wheeler, M. D.

____, 19__ (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Butte Cemetery, Ft. Hall Reservation, Io	5-29 19

20. Undertaker: Agency Carpenter, Ft. Hall, Idah — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68642

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 45

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME William Kelly

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	X

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86	X	X	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Poorfarm

9. BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10. NAME OF FATHER X

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) X

12. MAIDEN NAME OF MOTHER X

13. BIRTHPLACE OF MOTHER (city or town) X
(State or Country)

14. Informant Ed McKay
(Address) Hailey

15. Filed 1-4, 1930 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

FOX

16. DATE OF DEATH Dec 1, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to Dec 1, 1929
that I last saw him alive on Dec 1, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Senility - Senile Degeneration of Brain
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Endocarditis
(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. W. Fox, M. D.
12/2, 1929 (Address) E. W. Fox

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey Idaho	Dec 3 1929

20. Undertaker	Address
Harris & Amos	Hailey.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68643

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 46
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Julius E. Fredrickson 122

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary J. Fredrickson

6. DATE OF BIRTH (month, day and year): Nov 6 - 1878

7. AGE: Years 51 | Months | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kansas

PARENTS
10. NAME OF FATHER: William Fredrickson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....
12. MAIDEN NAME OF MOTHER: Rebecca Mathews
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Mary J. Fredrickson
(Address) Gannett - Idaho

15. Filed 1 - 4, 1930 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 - (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/1, 1929, to 12/2, 1929
that I last saw him alive on 12/2, 1929
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows: Cirrhosis of the liver non-alcoholic -
..... (duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) Chronic appendix
..... (duration) ..... yrs. 1 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of 11/29-29
Was there an autopsy? no.
What test confirmed diagnosis? Confirmed at operation
(Signed) E. W. [illegible] M. D.
12/3, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salem, Oregon | Date of Burial: Dec 6 1929

20. Undertaker: Harris & Amos | Address: Hailey Ida

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68644

PLACE OF DEATH
County of Blaine
City of Carey

Registration District No. 57
Primary Registration District No. 2025
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 47

111a

2. FULL NAME Mary Alice Rawson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: William F. Rawson

6. DATE OF BIRTH (month, day and year): June 20 1861

7. AGE: Years 68, Months 6, Days 3. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kaysville, Utah

PARENTS

10. NAME OF FATHER: Robert E. Wilson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....
12. MAIDEN NAME OF MOTHER: Mrs Blood
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant: Edward C. Rawson
(Address) 442 University Salt Lake City Ut

15. Filed 1-4, 1930 R. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 23 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929 to Dec 23, 1929
that I last saw her alive on Dec 23, 1929
and that death occurred, on the date stated above, at 1 o'clock p m.

The CAUSE OF DEATH* was as follows:
Gastric ulcer with cicatrical contraction of Duodenum & at seat of old Gastro enterostomy 12 years Previous (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical & x-Ray
(Signed) E. W. [signature], M. D.
12/24, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Carey Idaho
Date of Burial: 19

20. Undertaker: Harris & Amos
Address: Hailey Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68645

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 41

PLACE OF DEATH

County of Blaine
City of Hailey
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Mc Laughlin 164

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6. DATE OF BIRTH (month, day and year) Jan 9, 10 - 1839

7. AGE	Years	Months	Days	If LESS than 1 day,
	90	4	9	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10. NAME OF FATHER John Mc Laughlin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER .....
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant Mrs P. Mc Laughlin
(Address) Hailey Idaho

15. Filed 1-4, 1930 T. F. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929 to Dec 19, 1929
that I last saw h[illegible] alive on Dec 19, 1929
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Senility
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Original
(Signed) E. W. [illegible], M. D.
12/30, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey Idaho	Dec 26 1929
20. Undertaker	Address
Farris & Amon	Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68646

Local Registrar's No. 49

PLACE OF DEATH

County of Blaine

City of Gannett

Registration District No. 54

Primary Registration District No. 2222

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Christopher LeRoy Crone 31

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Minnie Crone

6. DATE OF BIRTH (month, day and year) Oct 8 - 1890

7. AGE	Years	Months	Days	If LESS than 1 day,
	39	3	16	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lamar, Mo.

PARENTS

10. NAME OF FATHER John Crone

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Ida Lilly

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Mrs. P. Barnhard
(Address) Marysville, Cal.

15. Filed 1 - 4, 1930 M. C. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/26, 1929, to 12/24, 1929, that I last saw h~~im~~ alive on 12/24, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis of Lungs

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Influenza. Patient had T.B. 12 yrs previous (duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopical

(Signed) E Wilson, M. D.

12/25, 1929 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bellevue - Ida	Dec 27 1929

20. Undertaker	Address
Harris & Amos	Hailey Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REC'D JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68647

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 50

PLACE OF DEATH

County of Blaine
City of Bellevue

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Michael Werry

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Werry

6. DATE OF BIRTH (month, day and year) Sept 3 - 1849

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	4	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Cornwall England

PARENTS

10. NAME OF FATHER Wm Werry

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER X

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant C. Werry
(Address) Bellevue, Idaho

15. Filed 1 - 4, 1930 C. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/23, 1929, to 12/26, 1929
that I last saw h~~im~~ alive on 12/26, 1929
and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

..... (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) C. W. Fox, M. D.
12/27, 1929 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bellevue, Ida	12-28 1929
20. Undertaker Harris & Sons	Address Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 4 1930

PLACE OF DEATH

County of Bonner

City of Priest River

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 85

Primary Registration District No. 2185

(No.)

DO NOT WRITE IN THIS SPACE

State File No. 68648

Local Registrar's No. 34

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

92

2. FULL NAME Charles Harry Clark

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day and year) Dec. 29, 1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Paris
(State or country) Kentucky

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) "

14 Informant G. W. Scott

(Address) Priest River, Idaho

15 Filed Dec. 4, 1929 J. E. Wessa
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
December (Month) 3, (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from December 2, 1929, to December 3, 1929
that I last saw him alive on December 2, 1929,
and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Primary — Embolism
Secondary — 1. Vegetative endocarditis
2. Pleurisy with effusion
3. Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical, Autopsy

(Signed) E. R. Spohn, M. D.

Dec 3, 1929 (Address) Priest River Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
I. O. O. F. Cemetery	12/4 1929

20. Undertaker Address

Moon Mortuary Priest River

JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68649

Registration District No. 78
Primary Registration District No. 2135
Local Registrar's No.

PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Jeanette Irish

(a) Residence. No. Dover Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
11	1	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montana

PARENTS
10. NAME OF FATHER Archie Irish
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn
12. MAIDEN NAME OF MOTHER Odell Elberton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Archie Irish
(Address) Dover Ida

15. Filed 1-3, 1930 Floyd G. Wendle
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Dec 24, 1929
that I last saw h[illegible] alive on Dec 24, 1929
and that death occurred, on the date stated above, at 8:30 A m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Wm F. Tyler, M. D.
Dec 26, 1929 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	12/26 1929
20. Undertaker	Address
Turnbull Co.	Sandpoint.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68650

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 215-5
Local Registrar's No.
(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Erik George Erickson

(a) Residence. No. Selle Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 5 1908

7. AGE	Years	Months	Days	If LESS than 1 day,
	21	3	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumber worker
(b) General nature of industry, business, or establishment in which employed (or employer) Humbird Lbr Co
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Matt Erickson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland
12. MAIDEN NAME OF MOTHER Louisa Simonson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant Fred Erickson
(Address) Selle

15. Filed 1-3, 1930 Floyd G. Wendle
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Dec 18, 1929
that I last saw him alive on Dec 18, 1929
and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) Wm F. Tyler, M. D.
Dec 21, 1929 (Address) Lakepoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	12/22 19
20. Undertaker	Address
Funeral Co	Sandpoint Ida

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68652

PLACE OF DEATH
County of Bonner
City of Samuels
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alma A. Saunders

(a) Residence. No. St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William B. Saunders

6. DATE OF BIRTH (month, day and year) December 4, 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	0	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Robert P. Messenger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Catherine Michael
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant F.M.Saunders
(Address) Samuels, Idaho.

15. Filed 12-31, 1929 Floyd G Weadle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 27, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1927, 19..., to 1929, 19...
that I last saw her alive on Dec-26, 1929
and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart disease
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Arterio-Sclerosis
(duration) 5 yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Floyd G Weadle M. D.
Dec. 31, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rolfe, Iowa.	JAN. 1, 1930

20. Undertaker	Address
MOON MORTUARY	SANDPOINT, IDA.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68653

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1185

2. FULL NAME Fred A Hardy

(a) Residence. No. 201 First St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 30 1856

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	0	3	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Hampshire

PARENTS

10. NAME OF FATHER F A Hardy

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unobtainable

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant G A Young
(Address) Sandpoint Idaho

15. Filed 1-3, 1930 Floyd G Wendle, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28, 1929, to Dec 2, 1929, that I last saw him alive on Dec 2, 1929, and that death occurred, on the date stated above, at 4:35 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

Dec 4, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Dec 5 1929
20. Undertaker	Address
Turnbull Co	Sandpoint.

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68654

PLACE OF DEATH
County of Bonner
City of Hope

Registration District No. 88
Primary Registration District No. 2157

Local Registrar's No. 13

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minerva Ophelia Foster.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Foster.

6. DATE OF BIRTH (month, day and year) Nov. 11, 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	—	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Battle Creek Michigan

PARENTS
10. NAME OF FATHER Mosly Potter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York.
12. MAIDEN NAME OF MOTHER Abragail Ormsby
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York.

14. Informant Edward Foster.
(Address) Hope, Idaho.

15. Filed Dec. 12, 1929. John Larson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929 to Nov 20, 1929
that I last saw h[illegible] alive on Nov 20, 1929
and that death occurred, on the date stated above, at 11:00 p. m.
The CAUSE OF DEATH* was as follows:
Chr nephritis
Cerebral hemorrhage
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? Clinical
(Signed) A. H. Ross M. D.
12/12, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hope Cemetery. Date of Burial Dec. 11, 1929

20. Undertaker Moon Mortuary Address Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68655

PLACE OF DEATH
County of Bonner
City of Hope

Registration District No. 80
Primary Registration District No. 2157
(No.) (b)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14

2. FULL NAME ENOCH VAN STONE

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of MAMIE VAN STONE

6. DATE OF BIRTH (month, day and year) SEPT. 16, 1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	2	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ENGINEER
(b) General nature of industry, business, or establishment in which employed (or employer) RAILWAY & STATIONARY
(c) Name of employer RETIRED 10 years

9. BIRTHPLACE (city or town) (State or country) ENGLAND

PARENTS

10. NAME OF FATHER JOHN VAN STONE

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ENGLAND

12. MAIDEN NAME OF MOTHER ELIZABETH SYMONS

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ENGLAND

14. Informant Mamie Van Stone
(Address) HOPE? IDAHO

15. Filed Dec 24, 1929 John Larson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 21, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24, 1929, to Dec 29, 1929
that I last saw him alive on Nov. 5, 1929
and that death occurred, on the date stated above, at 2:25 A.m.
The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis & Nephritis (duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Wm. F. Tyler, M. D.
Dec. 22, 1929 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
HOPE, IDAHO.	Dec. 23 1929

20. Undertaker	Address
MOON MORTUARY	SANDPOINT, IDAHO.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68656

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 214-0
(No. ....)
Local Registrar's No. 236

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth Telford

(a) Residence. No. 1 Idaho Falls Route 7 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Idaho

PARENTS

10. NAME OF FATHER: L. Telford
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Preston, Utah
12. MAIDEN NAME OF MOTHER: La Vinna Park
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Rexburg Idaho

14. Informant: Mrs. L. Telford
(Address): Idaho Falls #7

15. Filed Dec 7, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Dec 5, 1929
that I last saw her alive on Dec 4, 1929
and that death occurred, on the date stated above, at 6 a.m.
The CAUSE OF DEATH* was as follows:

Measles

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary): Mal-nutrition

(duration) ... yrs. 4 mos. 1 ds.

18. Where was disease contracted if not at place of death? same
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination

(Signed) J. [illegible], M. D.
12/7, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho — Date of Burial: Dec 7 1929
20. Undertaker: Jack A. Ward — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68657

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 13
Primary Registration District No. 2150
(No. County Hospital (NE of 1st. Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 234

129

2. FULL NAME John Edmondson
(a) Residence. No. North-east of First St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Not known.

6. DATE OF BIRTH (month, day and year): Not known.

7. AGE: About 80 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sheep-herder
(b) General nature of industry, business, or establishment in which employed (or employer): (Civil War Veteran)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): ~~Not-known~~ Missouri

PARENTS

10. NAME OF FATHER: Not known.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known.
12. MAIDEN NAME OF MOTHER: Not known.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known.

14. Informant: Mrs. Chas. Lundstrum
(Address) No. Holmes Ave. - Idaho Falls

15. Filed 12/23, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 20 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on Oct. 23, 1929
and that death occurred, on the date stated above, at 1:30 P.m.
The CAUSE OF DEATH* was as follows:
Chronic nephritis
myocarditis
(duration) ? yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) [signature], M. D.
12/23, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rose Hill Idaho Fallls
Date of Burial: Dec. 23 1929

20. Undertaker: Jack A. Wood
Address: Idaho Falls Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68658

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2170

Local Registrar's No. 234

(No. County Hospital (West 14th. St.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Henry LeDin

(a) Residence. No. West 14th. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Not known.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Not known.

6. DATE OF BIRTH (month, day and year) Dec. 25, 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	76	11	27	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Not known.

(b) General nature of industry, business, or establishment in which employed (or employer) (Phillipine War Vet.)

(c) Name of employer

9. BIRTHPLACE (city or town) Not known.
(State or country)

PARENTS

10. NAME OF FATHER Not known.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Not known.

12. MAIDEN NAME OF MOTHER Not known.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Not known.

14. Informant Mrs. Eva Eklund
(Address) 228 W. 14th. St.

15. Filed 1/2/30, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. 22 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
[illegible], 19[illegible], to [illegible], 19[illegible]
that I last saw h[illegible] alive on Dec. 22, 1929
and that death occurred, on the date stated above, at 1:40 P.m.

The CAUSE OF DEATH* was as follows:
Chronic nephritis
Chronic hypertension.

(duration) ? yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Sx.

(Signed) [illegible], M. D.

Dec 23, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rose Hill--Idaho Falls	Dec. 28, 1929

20. Undertaker Jack A. Wood Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68659

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 1 N 0

Local Registrar's No. 233

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

91B

2. FULL NAME John D. Seyfert.
(a) Residence. No. 4 Miles So of Idaho Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Lena Seyfert.

6. DATE OF BIRTH (month, day and year): Feb 8-1866.

7. AGE: Years 63 | Months 9 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10. NAME OF FATHER: Theodore Seyfert.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.
12. MAIDEN NAME OF MOTHER: Amelia Laudeman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany.

14. Informant: Mrs Lena Seyfert.
(Address) Idaho Falls Ida.

15. Filed 12/23, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928, to Dec 22, 1929
that I last saw him alive on Dec 15, 1929
and that death occurred, on the date stated above, at 1.30 P. m.
The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) [signature], M. D.
12/24, 1929 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida | Date of Burial: Dec 24 1929

20. Undertaker: V. F. McHan | Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68660

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 210
Local Registrar's No. 232

(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1610

2. **FULL NAME** Baby Dennis.

(a) Residence. No. 179 - 5th St. Idaho Falls, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	baby

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hours / min.
			5 Hours

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER Garrison Dennis.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho Falls

12. MAIDEN NAME OF MOTHER Beatrice Dennis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St Anthony, Idaho

14. Informant Father
(Address) Idaho Falls. Idaho

15. Filed 12/24, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1929, to Dec 21, 1929
that I last saw her alive on Dec 21, 1929
and that death occurred, on the date stated above, at 2 20 m.

The CAUSE OF DEATH* was as follows: Premature birth
(7 mo)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature separation of Placenta.

(duration) yrs. mos. 2 hrs

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D.

Dec 21, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cremated	12/31 1929

20. Undertaker none

Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68661

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 214-0

Local Registrar's No. 231

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Paren U. Day.

(a) Residence. No. 344 N. Water Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Alice (P. U.) Day

6. DATE OF BIRTH (month, day and year): Nov 15 1864.

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65	1	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Keeper of a.

(b) General nature of industry, business, or establishment in which employed (or employer): Boarding House.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio.

PARENTS

10. NAME OF FATHER: John Day.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland.

14. Informant: Mrs P. U. Day.
(Address) 344 N. Water Ave

15. Filed 12/17, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1922 to Dec 18, 1929 that I last saw him alive on Dec 18, 1929 and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:
Chronic nephritis
Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Same

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical-Urinalysis

(Signed) [signature], M. D.

Dec 19, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida — Date of Burial: Dec 22 1929

20. Undertaker: V. F. McHan — Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68662

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2150

Local Registrar's No. 230

(No. Ex-D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

201

2. FULL NAME Christy Minet

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years: About 30. Months: Days: If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Ranch Hand

(b) General nature of industry, business, or establishment in which employed (or employer): S. C. Albiano

(c) Name of employer: Spencer Idaho

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mary Minet

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Buffalo N.Y.

14. Informant: Mr. Hugh Wood

(Address): Spencer Idaho

15. Filed 12/19, 1925 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 18 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1929, to Dec 18, 1929

that I last saw him alive on Dec 18, 1929

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Fractured Skull

Piece of well pipe dropped loosening crowbar 17 hours which hit man in head

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Central Hemorrhage

(duration) yrs. mos. 17 hrs ds.

18. Where was disease contracted if not at place of death? Spencer, Idaho

Did an operation precede death? Yes No Date of Dec 17-1929

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

....., 19.... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Buffalo N.Y. Date of Burial: Ent. Shipm. Dec 19 1929

20. Undertaker: V. F. McHan Address: Idaho Falls Idaho

RECEIVED MAY 14 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68662

Dr. C.M. Cline
Idaho Falls, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Christy Minet who died Dec. 18, 1929at Idaho Falls, Idaho
Cause of death given as "Fractured Skull" "Cerebral Hemorrhage"

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO PLEASE STATE THE PLACE WHERE IT OCCURRED.

PLEASE ANSWER BELOW:

Piece of well pipe dropped, loosening crow bar which hit man in head producing skull fracture.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68663

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22

201

2. FULL NAME Niels Nelsen Holm
(a) Residence. No. Shelley, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Holm

6. DATE OF BIRTH (month, day and year): Oct 26, 1853

7. AGE: Years 76 | Months 1 | Days 14 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Surveyor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Denmark

PARENTS
10. NAME OF FATHER: Nelsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Geo. F. Lofgren
(Address) Shelley, Idaho, Box 96

15. Filed 12/12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9, 1929, to Dec 10, 1929
that I last saw h... alive on Dec 10, 1929
and that death occurred, on the date stated above, at 1-10 P m.
The CAUSE OF DEATH* was as follows:
Fractured Skull
Stepped of bus hit by passing car on hiway entering Idaho Falls (duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Central Hemorrhage
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Shelley, Idaho
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? X ray
(Signed) [signature], M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shelley, Idaho | Date of Burial: Dec 12 1929

20. Undertaker: Jack A. Wood | Address: Idaho Falls

RECEIVED MAY 14 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68663

Dr. C.M. Cline
Idaho Falls, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Niels Nelsen Holm who died at Idaho Falls, Idaho on Dec. 10, 1929
Cause of death given as "Fractured Skull" "Cerebral Hemorrhage"
Information DESIRED in order to complete certificate:
PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH.
IF AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Stepped out of Bus. hit by passing car, on highway entering Idaho Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68664

PLACE OF DEATH

County of Bonneville. Registration District No. 23

City of Idaho Falls. Primary Registration District No. 214-0 Local Registrar's No. 27

(No. The L. D. S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Infant Fowler.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 1 1929.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
no	no	no	9

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls

PARENTS

10. NAME OF FATHER P. H. Fowler.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Georgia Labrum.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sandy, Utah.

14. Informant P. H. Fowler
(Address) Idaho Falls, Ida.

15. Filed 12/7, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 2 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1929, to Dec. 2, 1929,
that I last saw her alive on Dec. 1, 1929
and that death occurred, on the date stated above, at 6:40 a. m.

The CAUSE OF DEATH* was as follows:

Premature Infant.
No other Cause known.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Harry L. Wilson M. D.
12/3, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida.	Dec 3 1929

20. Undertaker	Address
T. F. M. Han	Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58665

Registration District No. 73

Primary Registration District No. 14-0

Local Registrar's No. 22

PLACE OF DEATH

County of Bonneville

City of Lewisville

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Glen Herbert Lindstrom

(a) Residence. No. Lewisville, Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 29 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	9	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewisville Idaho

PARENTS

10. NAME OF FATHER G. A. Lindstrom

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Ethel Rydberg

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Chicago Ill.

14. Informant G. A. Lindstrom

(Address) Lewisville Idaho

15. Filed Dec 1, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929, to Nov 29, 1929, that I last saw him alive on Nov 28, 1929, and that death occurred, on the date stated above, at 9:15 A m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) H. D. Luedtke, M. D.

Dec 2, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewisville	Dec. 1 1929
20. Undertaker	**Address**
Jack A. Hood	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68666

PLACE OF DEATH
County of Bonneville
City of Poplar

Registration District No. 73
Primary Registration District No. 2140
(No. Kettenring Chiropractic Sanitarium
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22

2. FULL NAME Zelpha Ruth H Keeler

(a) Residence. No. Poplar, Idaho - St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Arnold Wholder

6. DATE OF BIRTH (month, day and year) Sept. 14, 1903

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	2	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lorenzo - Idaho

PARENTS

10. NAME OF FATHER Thomas H. Clifford
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Teton Valley Idaho.
12. MAIDEN NAME OF MOTHER Edith M. Burch
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ogden Utah

14. Informant Thomas H. Clifford
(Address) Antelope, Idaho -

15. Filed Dec 4, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 28, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13, 1929, to Nov 28, 1929, that I last saw her alive on Nov 28, 1929, and that death occurred, on the date stated above, at 8:45 P m.

The CAUSE OF DEATH* was as follows:
Rheumatism and Albumen Poisoning of Valvular leakage of heart
(duration) yrs. 9 mos. ds.
CONTRIBUTORY (Secondary) Valvular Leakage of heart (duration) yrs. mos. 16 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H W Call M. D.
Nov 30, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shelton, Idaho	Dec. 1 1929

20. Undertaker Jack R. Hood
Address Idaho Falls

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68667

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2 1 N - 0
Local Registrar's No. 224
(No. Spencer Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Rasmussen 41
(a) Residence. No. 1 Idaho Falls, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 3, 1901

7. AGE	Years	Months	Days	If LESS than 1 day,
	27	11	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Graduate Nurse
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Poplar, Idaho

PARENTS

10. NAME OF FATHER George H. Rasmussen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Farmington, Utah
12. MAIDEN NAME OF MOTHER Rose Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Coy Bountiful, Utah

14. Informant G.H. Rasmussen
(Address) Idaho Falls Route #5

15. Filed Dec 23, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16, 1929, to Nov 23, 1929
that I last saw h[illegible] alive on Nov 23, 1929
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:

Staph-Cocci in Blood Stream
from infection in finger
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? ✓
What test confirmed diagnosis? ✓

(Signed) H.D. Spencer, M. D.
Dec 2, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho	Nov 29 1929
20. Undertaker Jack A. Ward	Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 1 9 1929

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 73
Primary Registration District No. 21 V-0

DO NOT WRITE IN THIS SPACE
State File No. 68668

Local Registrar's No. 223

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harriet Bitton Poole

(a) Residence. No. Shuttleworth Apts. Idaho Falls
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John R. Poole

6. DATE OF BIRTH (month, day and year) April 14, 1846

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	7	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER John Bitton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Ida Smith
(Address) Idaho Falls, Idaho

15. Filed Nov 30, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929, to Nov 3, 1929, that I last saw her alive on Nov 3, 1929, and that death occurred, on the date stated above, at 10:32 A. m.

The CAUSE OF DEATH* was as follows:
Senile Gangrene

(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical
(Signed) [signature] M. D.
Dec 2, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cedar Butte	Nov. 30 1929
20. Undertaker Jack A. Hood	Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 19 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68669

Registration District No. 73

Primary Registration District No. 2140

Local Registrar's No. 222

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1612

2. FULL NAME Baby Boy Norell

(a) Residence. No. Idaho Falls, Idaho St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) November 27, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER E. H. Norell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ammon, Idaho

12. MAIDEN NAME OF MOTHER Dorothy Lyon Norell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Springfield, Illinois

14. Informant Mrs. E. H. Norell

(Address) Idaho Falls, Idaho

15. Filed Dec. 2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26, 1929, to Nov 27, 1929, that I last saw h[illegible] alive on Nov 27, 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Not Known

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [signature], M. D.

....., 19.... (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ammon, Idaho	Nov 29 1929
20. Undertaker	Address
Jack A. Wood	Idaho Falls

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68670

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2170
Local Registrar's No. 221
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Claus Goettsche

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) August 16-1862

7. AGE: Years 67, Months 3, Days 13. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Germany.

PARENTS
10. NAME OF FATHER: Claus Goettsche Sr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs Theresa Eggers Goettsche
(Address) Swan Valley.

15. Filed Nov 29, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24, 1929, to Nov 27, 1929
that I last saw him alive on Nov 27, 1929
and that death occurred, on the date stated above, at 5.15 P.m.
The CAUSE OF DEATH* was as follows:
Chr. Myocarditis
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chr. Parenchymatous
(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? Irwin, Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) [signature], M. D.
....., 19.... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nixon Idaho
Date of Burial: Nov 31 1929.
20. Undertaker: V. F. McHan
Address: Idaho F.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68672

PLACE OF DEATH
County of Bonneville
City of Ogood

Registration District No. 73
Primary Registration District No. 2150

Local Registrar's No. 219

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harold Cunningham

(a) Residence. No. Ogood, Idaho St. (Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 27, 1913

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	2	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Newdale, Idaho

PARENTS

10. NAME OF FATHER George J. Cunningham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Stoterville, Utah
12. MAIDEN NAME OF MOTHER Mary L. Hammon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hooper, Utah

14. Informant George J. Cunningham
(Address) Idaho Falls Route #7

15. Filed 11/27, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 25 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
That I last saw h alive on , 19
and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:
Arthritis Deformans
Invalid from birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis of Bowels

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) [illegible] M.D.
11/27, 1929 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Woodville, Idaho	Nov 27 1929

20. Undertaker Jack A. Wood — Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68673

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
Local Registrar's No. 21

(No.) 88B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sullivan John Walker
(a) Residence. No. North Part of town
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Vellman Walker

6. DATE OF BIRTH (month, day and year) Feb. 4 - 1859.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
70	9	20.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Springfield Wis.

PARENTS
10. NAME OF FATHER Silas Walker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Sarah Knowles.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Sullivan J Walker
(Address) Idaho Falls Ida.

15. Filed 11/25, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ; 19 , to , 19
that I last saw him alive on , 19
and that death occurred, on the date stated above, at 10 A. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
Senility (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? History
(Signed) Dr. [signature] M.D.
Nov 25, 1929 (Address) Coroner Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ucon Ida. Date of Burial: Nov 27 1929

20. Undertaker: V. F. McHan Address: Idaho Falls.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68674

PLACE OF DEATH
County of Bonneville
City of Swan Valley

Registration District No. 73
Primary Registration District No. 2150
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 217

74a

2. FULL NAME Dick Fischer
(a) Residence. No. Swan Valley, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) March 24, 1866
7. AGE Years 63 Months 7 Days 28 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Herman Winterfeld
(Address) Swan Valley, Idaho

15. Filed Nov 25, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 9-30 m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage, Apoplexy
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) [illegible]
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ——
Did an operation precede death? No Date of ——
Was there an autopsy? No
What test confirmed diagnosis? Examination + history
(Signed) [illegible] Coroner
Nov. 25-29 19.. (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho Date of Burial Nov 25 1929
20. Undertaker Jack A. Wood Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68675

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 210-0
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 216

100a

2. FULL NAME Lewis Clark Burgee
(a) Residence. No. Bone, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) July 19, 1928
7. AGE Years 1 Months 4 Days 11 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Bone, Idaho

PARENTS
10. NAME OF FATHER C. F. Burgee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oxford, Idaho
12. MAIDEN NAME OF MOTHER Barbara Rhoades
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mendon, Utah

14. Informant C. F. Burgee
(Address) Bone, Idaho

15. Filed Nov. 25, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9, 1929, to Nov 20, 1929
that I last saw him alive on Nov 20, 1929
and that death occurred, on the date stated above, at 3-30 P m.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(duration) yrs. mos. 9 ds.
CONTRIBUTORY (Secondary) Acute Myocarditis
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Ozone
Did an operation precede death? Thoracentesis Date of 11/18/29
Was there an autopsy? No
What test confirmed diagnosis? Lab & etc
(Signed) [signature], M. D.
11/21, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Teton, Idaho
Date of Burial Nov 22 1929
20. Undertaker Jack A. Ward
Address Idaho Falls

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68676

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 215-0
Local Registrar's No. 215
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myrtle Minerva Cutler

(a) Residence. No. Newdale St. Ida
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

101A

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin Cutler

6. DATE OF BIRTH (month, day and year) 3-25-1869

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	7	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer at home

9. BIRTHPLACE (city or town) (State or country) Leeds Utah

PARENTS

10. NAME OF FATHER Silas Harris

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Sarah Aldridge

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Edwin Cutler
(Address) Shelley Ida

15. Filed Dec 23, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) – 18 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-17-, 1929, to 11-18-, 1929
that I last saw her alive on 11-18-, 1929
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia.
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Acute dilation of heart
(duration) 6 hours yrs. mos. ds.

18. Where was disease contracted if not at place of death? Newdale Ida
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Edwin Cutler M. D.
11-18-, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shelley Cemetery	11-21-1929
20. Undertaker Jack A. Wood	Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68677

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 3
Primary Registration District No. 2140
(No. The D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 214

2. FULL NAME Johanna Christiene Safstrom
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) March 18-1852
7. AGE: Years 77, Months 7, Days 29. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Sweden.

PARENTS
10. NAME OF FATHER: Johanas Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden.
12. MAIDEN NAME OF MOTHER: Anna L. Carlson.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden.

14. Informant: S. G. Safstrom
(Address) Idaho Falls Ida.
15. Filed Nov 14, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 18 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 27th, 1929, to Nov. 17, 1929
that I last saw her alive on Nov 17, 1929
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows:
Septicemia
Abscesses Rt. antler and Right Shoulder.
(duration) ..... yrs. ..... mos. 21 ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? -
Did an operation precede death? yes Date of Oct 28-29
Was there an autopsy? no
What test confirmed diagnosis? -
(Signed) A. R. Soderquist, M. D.
11/18, 1929 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: New Sweden Cemetery
Date of Burial: 11/20 1929
20. Undertaker: T. F. McHan
Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 19 1929

PLACE OF DEATH

County of Bonneville

City of Idaho Falls, Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 98

Primary Registration District No. 2176

(No. Spencer Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68678

Local Registrar's No.

2. FULL NAME William Jones.

(a) Residence. No. St. Rigby, Idaho. 74a

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced HUSBAND of ~~WIFE~~ Annie Jones.

6. DATE OF BIRTH (month, day and year) Nov. 26 1858

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	11	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9. BIRTHPLACE (city or town) (State or country) Wales.

PARENTS

10. NAME OF FATHER David Jones.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales.

12. MAIDEN NAME OF MOTHER Ann Jones.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales.

14. Informant Annie Jones

(Address) Rigby, Idaho.

15. Filed 12-1, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7, 1929 to Nov-16, 1929 that I last saw h~~im~~ alive on Nov 7 5 1929 and that death occurred, on the date stated above, at 6 46 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Nov 16, 1929 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho.	11/19/29

20. Undertaker [illegible] Address Rigby

ohio must have been overlooked

RECEIVED JAN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68679

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 3
Primary Registration District No. 2007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

5-4a

2. FULL NAME Kenneth Hubert Lee
(a) Residence. No. Parma Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 24- 1925

7. AGE Years 3 Months 10 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Hurcles Mo.
(State or country)

PARENTS

10. NAME OF FATHER W J Lee.
11. BIRTHPLACE OF FATHER (city or town) Hurcles Mo.
(State or Country)
12. MAIDEN NAME OF MOTHER Armeda Hicks
13. BIRTHPLACE OF MOTHER (city or town) Long Run Mo.
(State or Country)

14. Informant Walsie Wyman
(Address)

15. Filed Jan 1, 1930 Lulu Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1929, to Aug. 23, 1929
that I last saw him alive on Aug. 21, 1929
and that death occurred, on the date stated above, at Dont know m.
The CAUSE OF DEATH* was as follows:
Pernicious Anemia

Dont know (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Staphlococcic infection of throat
Dont know (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Dont know
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & Laboratory
(Signed) W. E. Waldrop M. D.
Sept. 9, 1929 (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Parma cemetery
Date of Burial Aug. 25 1929

20. Undertaker Peckham Fur. Co
Address Parma, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68680

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 150

(No. Meray Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Workman

(a) Residence. No. Near Melba St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 22

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
15	9	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ap Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Melba, Idaho

PARENTS

10. NAME OF FATHER F. P. Workman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nevada

12. MAIDEN NAME OF MOTHER Sarah Gardner

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wyo.

14. Informant F. P. Workman
(Address) Nampa Ida

15. Filed 12-30, 1929 Bertha Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 3 PM 1929, to Dec 29 7 PM 1929
that I last saw him alive on Dec 29, 1929
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:

Shot gun wound of head. Entering temple, coming through right eye and out through nose.
(duration) yrs. mos. Hours ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) V. C. Bullard M. D.
Dec 30, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn	19
20. Undertaker	Address
L. K. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

B

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 58681

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 149

(No. 1109 - 9th St. So.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frankie Duncan

(a) Residence. No. 1109 - 9th St. So. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 6th 1869

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	60	8	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER David D. Duncan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Richmond Ohio
12. MAIDEN NAME OF MOTHER Martha Thompson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Richmond Ohio

14. Informant Mrs. J. W. Skadden
(Address) 1109-9th St. So. Nampa

15. Filed 12-28, 1929 Bertha Causey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-16, 1929 to 12-27, 1929
that I last saw her alive on 12-27 1929
and that death occurred, on the date stated above, at 11:30 P m.
The CAUSE OF DEATH* was as follows: Carcinoma of Left eye, with metastasis to the pubic bones.
(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Portland Ore.
Did an operation precede death? Yes Date of 1923
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. Horton, M. D.
12-28, 1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn - Nampa	12-29 1929
20. Undertaker	Address
Mrs. Nina M. Talley	Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS' should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68682

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 148
(No. Samaritan Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Amanda Scott 74a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry E. Scott

6. DATE OF BIRTH (month, day and year): Dec. 29th 1887

7. AGE: Years 41 | Months 11 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Albert Lee Minnesota

PARENTS

10. NAME OF FATHER: Otto Larsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Bettsy Stein
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Mr. H. E. Scott
(Address): Nampa, Idaho

15. Filed 12-27, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1929, to Dec. 24, 1929
that I last saw her alive on Dec. 24, 1929
and that death occurred, on the date stated above, at 10:10 P. m.
The CAUSE OF DEATH* was as follows: Cerebral Haemorrhage with paralysis
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) W. C. Notts, M. D.
12-27, 1929 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn, Nampa | Date of Burial: 19

20. Undertaker: Mrs. Nina M. Talley | Address: Nampa, Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68683

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 147

101a

2. FULL NAME Catherine Fish Brandtner

(a) Residence. No. Glenns Ferry St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: B. T. Brandtner

6. DATE OF BIRTH (month, day and year): May 16 - 1865

7. AGE: Years 64 | Months 7 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: Fish
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: B. E. Brandtner
(Address) Portland Ore.

15. Filed 12-24, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-16-, 1929, to 12-22-, 1929.
that I last saw her alive on 12-21-, 1929.
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia following Ether as general anaesthetic.
(duration) 0 yrs. 0 mos. 3 ds.
CONTRIBUTORY (Secondary) Adenocarcinoma of pylorus and Cholecystitis Carcinoma. 30 yrs. (duration) 0 yrs. 7 mos. 0 ds.

18. Where was disease contracted if not at place of death? Glenns Ferry, Idaho.
Did an operation precede death? Date of 12-16-29.
Was there an autopsy? No.
What test confirmed diagnosis? Phys. signs & Tissue Exam.
(Signed) Geo. P. C. Kellogg, M. D.
12-24-, 1929. (Address) Nampa, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Glenns Ferry Nampa Idaho | Date of Burial: 12-24 1929

20. Undertaker: F. K. Robinson | Address: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68684

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
(No. Nazarine Hospt. - Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 146

2. FULL NAME Andrew B. Switzer

(a) Residence. No. Middleton Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

41

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Jan 8 - 1858

7. AGE: Years 71 Months 11 Days If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ~~A Switzer~~ Ohio

PARENTS

10. NAME OF FATHER: A Switzer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Switzerland
12. MAIDEN NAME OF MOTHER: Julia Bamter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: C. Cornell
(Address) Middleton, Ida

15. Filed 12-23, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-18, 1929, to 12-22, 1929
that I last saw him alive on 12-22, 1929
and that death occurred, on the date stated above, at 5:30 P m.
The CAUSE OF DEATH* was as follows: Streptococci infection of left arm
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Scratch on back of left hand
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? yes
(Signed) W. C. Nolte, M. D.
12-23, 1929 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Guide Rock Nebo — Date of Burial: 12-24 1929

20. Undertaker: Fred K R Hinson — Address: Nampa Ida

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68685

Local Registrar's No. 145

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

(No. Samaritan)

(If death occurred in a hospital or institution, give its name instead of street and number.)

124

2. FULL NAME Francis M. Jewett

(a) Residence. No. Nampa Rural St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1870

7. AGE	Years	Months	Days	If LESS than 1 day,
	59			hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Orin Jewett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Mary Lyon

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs Ida Sutton

(Address) Nampa Idaho

15. Filed 12-26, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1929 to Dec. 22, 1929

that I last saw him alive on Dec. 22, 1929

and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Oedema of

Lungs (duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathology

(Signed) Samuel A Swayne M. D.

Dec. 26, 1929 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Nampa Ida.	
20. Undertaker F. K. Robinson	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HARDIN RESERVED FOR BINDING

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68686

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006

Local Registrar's No. 14

(No.) 74W
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME De Laney King

(a) Residence. No. 1103 - 11th Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 1 - 1845

7. AGE	Years	Months	Days	If LESS than 1 day,
	84	2	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) (retired)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Hanford King

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs D. L. King
(Address) Nampa Ida

15. Filed 12-14, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1929, to Dec. 12, 1929
that I last saw h alive on Dec. 8, 1929
and that death occurred, on the date stated above, at 2 p m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & Pathology
(Signed) Samuel A Swayne, M. D.
Dec. 14, 1929 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Ida	12-14-29
20. Undertaker	Address
F E Robinson	Nampa Ida

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68687

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 143
(No. ←)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John S. Lucas
(a) Residence. No. 9th ave + 10 th St. 11A
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ←

6. DATE OF BIRTH (month, day and year) June 8 - 1848

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	6	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Geo Lucas
(Address) Nampa Ida

15. Filed 12-10, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/8, 1929, to 12-8, 1929.
that I last saw him alive on 12-8, 1929
and that death occurred, on the date stated above, at 6 AM m.
The CAUSE OF DEATH* was as follows:
Pneumonia vesicular edema lungs. (Influenza type)
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Bronchitis.
(duration) yrs. 9 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of 12/8/29
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace P Belknap M. D.
12/9, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem	12-10 1929
20. Undertaker	Address
Fred K. Robinson	Nampa Ida

HPB

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68688

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Nampa Mountain Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 142

44

2. FULL NAME Emily Mills

(a) Residence. No. Hoover Wash St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	W	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 3 - 1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Wm Robson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Wm Mills
(Address) Hoover Wn

15. Filed 12-31, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-22, 1929, to 12-20, 1929
that I last saw her alive on 12-20, 1929
and that death occurred, on the date stated above, at 7:30 P m.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? X-ray & Gastric Analysis
(Signed) Thos. E. Montgomery M. D.
12-31, 1929 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kennedy Wash	1- 19
20. Undertaker	**Address**
T. K. Robinson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RE[illegible] JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68689

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. 323 - 8 ave S)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 141

74 B

2. FULL NAME J. Freemont Bow
(a) Residence. (Usual place of abode) No. 323 - 8th ave St. (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND ~~or~~ (or) ~~WIFE~~ of C. A. Bow

6. DATE OF BIRTH (month, day and year) 9-19-1857

7. AGE Years 62 Months 2 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Realtor
(b) General nature of industry, business, or establishment in which employed (or employer) (retired)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. Jersey

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Mrs C. A. Bow
(Address) Nampa, Ida

15. Filed 12-11, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Dec, 1929
that I last saw him alive on 12/8, 1929
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:
Embolus to brain.
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Endocarditis & myocarditis
(duration) yrs. 12 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace P Bilkner, M. D.
12/9, 1929 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa Ida
Date of Burial: 12-11 1929

20. Undertaker: F. K. Robinson
Address: Nampa Ida

FORM No. 5-A—25 M. 1-19 RECEIVED JAN 6 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. State Sanitarium St.)

File No. 68690

Registered No. 140

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida Lowery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 7 (Day) 1899 (Year)

7. AGE: 30 Yrs. Mos. 5 ds. 3

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: Oliver Lowery

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Leola Barnwell

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. Orr Poynter

(Address) Nampa, Ida

15. Filed 12-11 1929 Deetha Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-9-1929, to 12-10-1929, that I last saw her alive on 12-10-1929, and that death occurred on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. 405 ds.

(Signed) D. Orr Poynter M. D.

19 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 11 yrs. 5 mos. 10 days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Power Co. Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL 19

20. UNDERTAKER: F. K. Robinson

ADDRESS: Nampa Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

RECEIVED JAN 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68691

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 134
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME Ethel Lane Gillette
(a) Residence. No. 7th & Blaine St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of H. C. Gillette

6. DATE OF BIRTH (month, day and year)

7. AGE: 56 Years | Months: 11 | Days: 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Landandairy Ireland

PARENTS

10. NAME OF FATHER: Micheal Boyle Lane
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Isobel Hill
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: H. C. Gillett
(Address): Caldwell

15. Filed 12-13-, 1929. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to Dec 10, 1929
that I last saw her alive on Dec 10, 1929
and that death occurred, on the date stated above, at 5:30 p.m.
The CAUSE OF DEATH* was as follows: Cardiac embolus
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Myocarditis & paralysis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) J. M. Paley, M. D.
12-12-, 1929 (Address) Caldwell Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 12-13 1929

20. Undertaker: Paul L. Case
Address: Caldwell

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

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RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68692

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 135

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

50

2. FULL NAME Samuel D. Bates

(a) Residence. No. Caldwell #1 St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia A. Bates

6. DATE OF BIRTH (month, day and year): July 4 1861

7. AGE: Years 68, Months 5, Days 8. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Summit Co. Utah

PARENTS
10. NAME OF FATHER: .....
11. BIRTHPLACE OF FATHER (city or town) (State or Country): .....
12. MAIDEN NAME OF MOTHER: .....
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): .....

14. Informant: Mrs S. D. Bates
(Address) Caldwell R#1

15. Filed 12-17, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/5, 1929 to Dec 11, 1929
that I last saw him alive on Dec 9, 1929
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:
Sarcoma of hip
..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
12/14, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: Dec-15-1929

20. Undertaker: C. V. Peckham — Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68694

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas McClellan Lammey 74a

(a) Residence. No. 617 — 3 — 6th City St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 18 —

7. AGE Years 66 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Van Buren Indiana.

PARENTS

10. NAME OF FATHER Josiah Lammey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Nancy Lee Speed
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Marion Co. Iowa

14. Informant Mrs Verna Stitzel
(Address) Caldwell Ida

15. Filed 12-17-1929 John S. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 3, 1929, to Dec. 13, 1929
that I last saw him alive on Dec. 12, 1929
and that death occurred, on the date stated above, at 12-31 a.m.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. 5 mos. ds.
CONTRIBUTORY (Secondary) Pyorrhea and abscessed teeth (duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) C. R. Whittenberger M.D.
Dec. 14, 1929 (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Canyon Hill
Date of Burial Dec-15-1929

20. Undertaker G. V. Peckham
Address Caldwell Ida.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68695

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 138

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME Anna May Thompson

(a) Residence. No. 307 Albany St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of J. W. Thompson

6. DATE OF BIRTH (month, day and year) July 14.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Albany Illinois

PARENTS
10. NAME OF FATHER Chas. Nesbit.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine.
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St. Louis Mo.

14. Informant J. W. Thompson
(Address) Caldwell Ida

15. Filed 12-24- 1929 John L. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to Dec 17, 1929
that I last saw her alive on Dec 17, 1929
and that death occurred, on the date stated above, at 6-30 P m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. one mos. ds.
CONTRIBUTORY (Secondary) ?
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Stethoscope
(Signed) [illegible] M. D.
12/17, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	12/20- 1929
20. Undertaker	Address
C. V. Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68696

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

Local Registrar's No. 139

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

111a

2. FULL NAME Wm C Bicknell

(a) Residence. No. 1821 Everett St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Nellie F Bicknell

6. DATE OF BIRTH (month, day and year): June 28 1855

7. AGE: Years 74, Months 5, Days 23. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Atty at Law

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Parishville N Y

PARENTS

10. NAME OF FATHER: Carlos B Bicknell

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norwich Vt

12. MAIDEN NAME OF MOTHER: Louisa Carpenter

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Potsdam N Y

14. Informant: Alfred F Stone
(Address) 1414 Dearborn Caldwell Ida

15. Filed 12-21-, 1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 21-29 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18, 1929, to Dec 21, 1929

that I last saw him alive on Dec 20, 1929

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Peritonitis. (Ruptured Gastric Ulcer)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Ulcer of Stomach

(duration) 20 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 19

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Case M. D.

12/21, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill Cemetery — Date of Burial: Dec 22-29

20. Undertaker: Paul L. Case — Address: Caldwell Idaho

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68697

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 140

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME John M. Earner.
(a) Residence. No. 1314 Arthur St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lucy J. Earner

6. DATE OF BIRTH (month, day and year) June 3-1869

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60	6	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minonk. Illinois.

PARENTS

10. NAME OF FATHER Chas. Earner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Catharine Kane
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Lucy J. Earner
(Address) Caldwell Ida

15. Filed 12-26-1929. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16, 1929, to Dec 21, 1929
that I last saw him alive on Dec 21, 1929
and that death occurred, on the date stated above, at 9-50 P.m.
The CAUSE OF DEATH* was as follows:
Enlarged Thum

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Kidney & bladder

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) T. D. Turner, M. D.
Dec 26, 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pleasant Ridge
Date of Burial: 12/26 1929

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68698

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005

Local Registrar's No. 141

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Benj. F. Leach

(a) Residence. No. Saratoga Hotel St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Florence L. Leach

6. DATE OF BIRTH (month, day and year) June 18 1858

7. AGE: Years 71, Months 6, Days 6. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hotel Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mackinaw Illinois

PARENTS

10. NAME OF FATHER William Leach
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Mary Jane Ayers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Florence L. Leach
(Address) Caldwell Ida

15. Filed 12-24-1929 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1929, to Dec 22, 1929
that I last saw him alive on Dec 22, 1929
and that death occurred, on the date stated above, at 11-4-30 m.
The CAUSE OF DEATH* was as follows:
Apoplexy - Cerebral
(duration) ..... yrs. ..... mos. 6 ds.
CONTRIBUTORY (Secondary) Paralysis agitans
(duration) 11 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) T D Farrer, M. D.
12/24, 1929 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashland Ore
Date of Burial: 19

20. Undertaker: E. V. Peckham
Address: Caldwell Ida

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68699

Registration District No. 3
Primary Registration District No. 9005
Local Registrar's No. 142

PLACE OF DEATH

County of Canyon
City of Caldwell
(No.) 143
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lloyd W. Harrah

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 3-7 1892

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	10	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Alec Ballantyne

9. BIRTHPLACE (city or town) (State or country) Washington

PARENTS

10. NAME OF FATHER Wilbur Harrah
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Kate Warfield
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Ray Harrah
(Address) R F D Caldwell Idaho

15. Filed 1-30-, 1929 John S. Meyers
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Gunshot wound thru body.
Accidental.
(duration) yrs. mos. ds.
No inquest.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Paul L. Case Coroner. M. D.
Dec 30-29, 19 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Dec 30-29 19
20. Undertaker	Address
Paul L. Case	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68700

PLACE OF DEATH
County of Canyon
City of Huston

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 143

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ewen J. Heckathorn, 129

(a) Residence. No. Huston #2 St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary A Heckathorn

6. DATE OF BIRTH (month, day and year) Oct 5 1854

7. AGE Years 75 Months 1 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) Minister
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Union Co. Iowa

PARENTS
10. NAME OF FATHER Philip
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Roxy Thayer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Ewen E. Heckathorn
(Address) Huston #2

15. Filed 1-2-, 1930 John S. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-28, 1929, to 12-30, 1929
that I last saw him alive on 12-29, 1929
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis and Myocarditis.
..... (duration) ..... yrs. 8 mos. ..... ds.
CONTRIBUTORY (Secondary) ✓
✓ (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Urinary & Stethoscopic
(Signed) J. C. Horton, M. D.
12-31, 1929 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 1-2 1930

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

RECEIVED JAN 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68701

PLACE OF DEATH
County of Canyon
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
Local Registrar's No. 30
(No.) 164
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ferdinand Russell

(a) Residence. No. Soda Springs Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 16 - 1835

7. AGE	Years	Months	Days	If LESS than 1 day,
	94	2	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York State

PARENTS

10. NAME OF FATHER Robt Russell
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Ellis Rackley
(Address) Soda Springs Ida

15. Filed Dec 8 - 1929 Dr. Russell Zigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5, 1929, to Nov. 6, 1929
that I last saw her alive on Nov 6, 1929
and that death occurred, on the date stated above, at 11 9 m.
The CAUSE OF DEATH* was as follows:
Senile Decay

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) 0

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? 0 Date of ✓
Was there an autopsy? 0
What test confirmed diagnosis? ✓
(Signed) Ellis Rackley, M. D.
Nov 8, 1929 (Address) Soda Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Soda Springs Ida	Nov 8 1929
20. Undertaker	Address
C. L. Williamson	Soda Springs Ida

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68702

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101a

2. FULL NAME Bertha Taylor

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Arthur E Taylor

6. DATE OF BIRTH (month, day and year) Dec.22 1892

7. AGE	Years	Months	Days	If LESS than 1 day,
	37	10	12	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS

10. NAME OF FATHER P.A.Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Arkansas
12. MAIDEN NAME OF MOTHER Mary Milliken
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas

14. Informant Arthur E Taylor
(Address) Burley Idaho.

15. Filed 2-31-, 1929 F K Carter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov.4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct.25, 1929, to Nov.4th, 1929
that I last saw her alive on Nov.4, 1929
and that death occurred, on the date stated above, at 4:10 a. m.
The CAUSE OF DEATH* was as follows:
Lobar -
Pneumonia
(duration) — yrs. mos. 10 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) G. H. Cooper M. D.
11 Dec 9, 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Marion Co Arkansas	Nov.10 19

20. Undertaker D.E.J ohnson
Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68703

PLACE OF DEATH
County of Cassia
City of Burley
Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

179

2. FULL NAME Theodore Robert Pearson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 2 1927

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Payette Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Joe Pearson

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Oregon

12. MAIDEN NAME OF MOTHER Trudie Harvey

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Oklahoma

14. Informant Joe Pearson
(Address) Burley Idaho.

15. Filed Nov 6, 1929 J. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4, 1929, to Nov 5, 1929
that I last saw him alive on Nov 5 11 M, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Burned (Accidental)
Child fell in tub of hot water
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) negative
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Commons
(Signed) Hugh E Johnson, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette Ida	Nov. 8 1929
20. Undertaker D. E. JOHNSON	Address BURLEY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 2 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68703

Dr. H.E. Dean
Burley, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Theodore Robert Pearson who died at Burley, Idaho on Nov. 5, 1929
Cause of death given as "Burned (accidentally)"

Information DESIRED in order to complete certificate:

WILL YOU PLEASE STATE WHETHER OR NOT A BURNING BUILDING WAS INVOLVED? THESE ARE CLASSIFIED SEPARATELY.

PLEASE ANSWER BELOW:

Child fell in tub of hot water.

H. E. Dean

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68704

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

118a

2. FULL NAME William H Roberts

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Minnie Roberts

6. DATE OF BIRTH (month, day and year) Aug.10 1860

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	3	1	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10. NAME OF FATHER Griffith Roberts

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales

12. MAIDEN NAME OF MOTHER Mary Williams

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant W.C.Roberts
(Address) Burley Idaho.

15. Filed 1-2-31, 1929 F. H Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov.11 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 11-8-, 1929, to 11-11-, 1929
that I last saw h alive on 19
and that death occurred, on the date stated above, at 7.50P m.
The CAUSE OF DEATH* was as follows:
Strangulated Hernia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Surg Operation
(Signed) F H Cutler, M. D.
1-1-11-, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Nov.14 19
20. Undertaker D.E.JOHNSON.	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PH should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instruction on back of certificate.

County of Cassia

City of Burley

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Wyley Dow Dyer

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Katherine N Dwyer

6. DATE OF BIRTH (month, day and year) Aug.4 1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	3	9	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10. NAME OF FATHER Harvey Dyer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia

12. MAIDEN NAME OF MOTHER Bette Mcoy

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) West Virginia

14. Informant Mrs.Katherine Dyer

(Address) Oakley Idaho.

15. Filed 12-31-, 1929 F H Cutler

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov.13 1929

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8, 1929, to Nov 13, 1929

that I last saw him alive on Nov 13, 1929

and that death occurred, on the date stated above, at 3.[illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F H Cutler, M. D.

Nov 14, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Nov. 15 1929

20. Undertaker D.E.Johnson

Address Burley

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68706

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. 161a)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dwaine Tilley

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 21 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Idaho.

PARENTS

10. NAME OF FATHER Arthur Tilley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spanish Fork Utah

12. MAIDEN NAME OF MOTHER Ethel Judd

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pleasant Grove Utah

14. Informant Arthur Tilley
(Address) R-4

15. Filed 12-31-, 1929 F. H. Carter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 1.40 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Carter, M. D.

11-16, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pella Ida	Nov. 11 1929
20. Undertaker	Address
D. E. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68707

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

126

2. FULL NAME Marie Haycock

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Cecil Haycock

6. DATE OF BIRTH (month, day and year) March 24 1908

7. AGE	Years	Months	Days	If LESS than 1 day,
	21	7	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House# wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Eureka Utah

PARENTS

10. NAME OF FATHER Wilfred Woodruff Cannon

11. BIRTHPLACE OF FATHER (city or town) (State or Country) St George Utah

12. MAIDEN NAME OF MOTHER Marie Anderson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant W.W.Cannon
(Address) St.George Utah.

15. Filed Nov 20, 1929 F. H. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7, 19, to Nov 19, 1929
that I last saw h alive on Nov 19, 1929
and that death occurred, on the date stated above, at 2 50 P. m.
The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) No Statistics

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) F. H Cutler, M. D.
Nov 20, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St.George Utah	Nov 24 1929

20. Undertaker D.E.Johnson
Address Burley

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6870 8

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nathaniel Edgar Witcher 90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About	65		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Junk Dealer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant D.E.Johnson
(Address) Burley Ida

15. Filed 12-31-, 1929 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov.19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D.E.Johnson Co Coroner M. D.
Nov. 27, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burley Ida — Date of Burial: Nov.27 29

20. Undertaker: D.E.Johnson — Address: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68709

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Leota Maud Craner 36

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 23 1882

7. AGE: Years 47 | Months 6 | Days 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kansas

PARENTS

10. NAME OF FATHER: David Lodwick
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Lucy Reno
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: Geroge E Craner
(Address): Burley Idaho.

15. Filed 12-31-, 1929 F. K. Curtis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov-10th, 1929, to Nov 20th, 1929
that I last saw her alive on Nov. 19th, 1929
and that death occurred, on the date stated above, at 2.30A m.
The CAUSE OF DEATH* was as follows:
Tuberculas Peritonitis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes - Date of 11-20-29
Was there an autopsy? no
What test confirmed diagnosis? Operation + Laboratory
(Signed) W. H. Cooper, M. D.
11/24-, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burley Ida
Date of Burial: Nov.24 19

20. Undertaker: D.E.Johnson Address: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68710

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fredrick J Nissen

112

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 27 1874

7. AGE Years 55 Months 1 Days 24 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Frank Moench.
(Address) Burley Ida

15. Filed 12-31-, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 21 1929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Gastrorrhagia
due to ulcers.
dont know (duration) yrs. mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Ben Schultz, M.

Nov. 23, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida

Date of Burial Nov. 24 1929

20. Undertaker D. E. JOHNSON Address BURLEY IDA

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

...ITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

...item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS ...ate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-...is very important. See instruction on back of certificate.

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68711

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

88B

2. FULL NAME Frank Bennett

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Not Known

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE Years Months Days — About 40 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheep Herder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Taylor Sheep Co.

9. BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant P.D.Pace
(Address) Burley Ida

15. Filed 12-31, 1929 F H Culter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov.23 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 11-22-, 1929, to 11-22-, 1929
that I last saw him alive on 11-22-, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Alcohol
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Cont/mon
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Usual
(Signed) Joseph Hemstad, M. D.
11-29-, 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida — Date of Burial Nov. 20 1929

20. Undertaker D.E.JOHNSON BURLEY IDA. — Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 6872

Local Registrar's No.

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No.

Primary Registration District No.

(No. 184 E)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Johnston

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
~~(or) WIFE~~ of Rena Johnston

6. DATE OF BIRTH (month, day and year) Mar. 23 1887

7. AGE Years	Months	Days	If LESS than 1 day,
	42	8	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Wool Grower

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) North Ogden

PARENTS

10. NAME OF FATHER William E Johnston

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill

12. MAIDEN NAME OF MOTHER Mary Ann George

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant A.A.Johnston

(Address) Boise Ida

15. Filed 1-31, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23 1929, 19..., to ..., 19...

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Injuries received in Auto crash.

Neck broken (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D:E. Johnson Co Coroner/~~M. D.~~

Nov. 25, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Almo Ida	Nov.26 19

20. Undertaker	Address
D.E.Johnson	Burley

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6871 3

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frances Hellen Stephens

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 11 1914

7. AGE	Years	Months	Days	If LESS than 1 day,
	15	1	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wyoming

PARENTS

10. NAME OF FATHER Edmond A Stephens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Mary Stone
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant E.A.Stephens
(Address) Burley Ida

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3, 19 29, to Nov. 27, 19 29
that I last saw h alive on Nov 27, 19 29
and that death occurred, on the date stated above, at 4 A m.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
(duration) yrs. 2 mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Widal
(Signed) Thos E Dixon, M. D.
Nov 27, 19 29 (Address) Burley Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida (View)	19

20. Undertaker		Address
D.E.Johnson	Burley	Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6871 4

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101 B

2. FULL NAME Anice M Bryant

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of George W Bryant

6. DATE OF BIRTH (month, day and year) May 17 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	5	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER George W Lusk
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Huldah Shaw
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Mrs Mae Griffiths
(Address) Burley Idaho.

15. Filed Dec 11, 1929 F H Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 10 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Dec-10. 1929 to Dec. 10. 1929
that I last saw her alive on Dec. 10. 1929
and that death occurred, on the date stated above, at 12.30 A m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at Home
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Ralph Halstead M. D.
Dec 11, 1929 (Address) Burley.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greeley Colorado	19

20. Undertaker D.E. Johnson Burley Ida
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68716

PLACE OF DEATH

County of Cassia
City of Declo Ida

Registration District No. 120
Primary Registration District No. 2199
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

74a

2. FULL NAME Alva Amoza Sanner

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Louisa Sanner

6. DATE OF BIRTH (month, day and year) Dec. 26 1848

7. AGE	Years	Months	Days	If LESS than 1 day,
	81		3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Nathaniel Sanner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Persis Tippets
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Helen Mosso
(Address) Declo Ida

15. Filed January 9, 1930 Charles B. Reymer M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1929, to Dec 29, 1929
that I last saw him alive on Dec. 11, 1929
and that death occurred, on the date stated above, at 10:20 A. m.

The CAUSE OF DEATH* was as follows:
Apoplexy
Arteriosclerosis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E. V. Skinner M. D.
Dec. 29, 1929 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Oakley	Dec. 31 1929
20. Undertaker R. E. Johnson	Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 1 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68717

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Annetta S Pike

126

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur A Pike

6. DATE OF BIRTH (month, day and year) Dec. 31, 1875

7. AGE Years 53 Months 11 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS
10. NAME OF FATHER Stevenson S Stephenson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Annie Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant A. A. Pike
(Address) Burley Ida

15. Filed 1-22, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1929, to Dec 14, 1929, that I last saw her alive on Dec, 1929, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH was as follows:
Peritonitis.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Appendicitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at Home
Did an operation precede death? yes Date of Dec 13-29
Was there an autopsy? no
What test confirmed diagnosis? Visual
(Signed) Joseph Hemstad M. D.
Dec 15, 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida. Date of Burial Dec 17 1929

20. Undertaker D. E. Johnson Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68718

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101B

2. FULL NAME Mary E Merrick

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): July 4 1825

7. AGE: Years 104 | Months 4 | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): South Carolina

PARENTS

10. NAME OF FATHER: Custer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Mrs. Hattie Brown
(Address) Burley Ida.

15. Filed [illegible], 19[illegible] [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 4 1929
Nov 25 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25, 1929, to Dec 4, 1929
that I last saw her alive on Dec 4, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Joseph Hemstad M. D.
Dec 11, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burley Ida
Date of Burial: Dec. 6 1929

20. Undertaker: D. E. JOHNSON
Address: Burley Ida

RECEIVED JAN 1 [illegible] 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68719

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Pulsipher

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

100a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret Pulsipher

6. DATE OF BIRTH (month, day and year) Nov. 13 1870

7. AGE Years 59 Months Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER David Pulispher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Elizabeth Jacobson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Margaret Pulsipher
(Address) Declo Ida

15. Filed 1-2-, 1930 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 3 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1929 to Dec 3 - 1929, 19
that I last saw him alive on Dec 3 - 1929
and that death occurred, on the date stated above, at 9.50 A m
The CAUSE OF DEATH* was as follows:
Bronchs Pneumonia

(duration) yrs. mos. 6 d

CONTRIBUTORY (Secondary)
(duration) yrs. mos. d

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E. Dean, M. I
Dec 11, 1929 (Address) Burley Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLEN CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2 whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida
Date of Burial Dec. 7 1929 19

20. Undertaker D. E. JOHNSON BURLEY IDA.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68720

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME John Tilley

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nec 1 1929

7. AGE Years Months Days If LESS than 1 day, 4 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Burley Ida
(State or country)

PARENTS

10. NAME OF FATHER John William Tilley

11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Rula Marshall

13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)

14. Informant J.W.Tilley
(Address) Burley Ida

15. Filed 1-2-, 1930 F. H. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 1 1929
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Birth at 19 1.55 to A.M. 12/1/29, 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 6 A. m

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency.

(duration) yrs. mos. ds

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Ben Schultz M. D

, 19 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida

Date of Burial Dec. 2 1929

20. Undertaker D.E.JOHNSON BURLEY

Address

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Clearwater

City of Elk River

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 91

Primary Registration District No. 2168

(No. ..... St.)

File No. 68722

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marjorie Joan Cameron

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: December (Month) 23 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant ✓

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Elk River Id.

10. NAME OF FATHER: Ralph Wade Cameron

11. BIRTHPLACE OF FATHER (State or Country): Ashgrove Missouri

12. MAIDEN NAME OF MOTHER: Clara Marie Olson

13. BIRTHPLACE OF MOTHER (State or Country): Troy Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. R. W. Cameron

(Address) Elk River, Id.

15. Filed Jan. 7 1930 M. Hambly Local Registrar

MEDICAL CERTIFICATE OF DEATH

161a

16. DATE OF DEATH: December (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 23 1929, to Dec 25 1929, that I last saw her alive on Dec 24, 1929, and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. M. Hysted M. D.

Dec 1929 (Address) Elk River Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Troy, Idaho

DATE OF BURIAL ..... 19.....

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. RECEIVED JAN 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2168
File No. 6823
Registered No. 6

1. PLACE OF DEATH
County of Clearwater
City of Elk River (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris Marion Torgerson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: infant. (Write the word.)

6. DATE OF BIRTH: Dec (Month) 11 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Elk River, Id.

10. NAME OF FATHER: George Henry Torgerson.

11. BIRTHPLACE OF FATHER (State or Country): Park, Id.

12. MAIDEN NAME OF MOTHER: Julia Bell Nolan

13. BIRTHPLACE OF MOTHER (State or Country): Harrison Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Henry Torgerson
(Address) Elk River Id.

15. Filed Jan. 7 1930 M. Hambly Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1929, to Dec 16 1929 that I last saw h alive on Dec 15 1929, and that death occurred on the date stated above, at 6 00 M.
The CAUSE OF DEATH* was as follows:
Atelectasis
..... (Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O M Knusted M. D.
Dec 16 1929 (Address) O M Knusted

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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REC'D JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68725

Registration District No. 90 2187
Primary Registration District No.
Local Registrar's No. 116

PLACE OF DEATH
County of Clearwater
City of Orofino
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. **FULL NAME** Charles M. Long

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of .

6. DATE OF BIRTH (month, day and year) April 1866

7. AGE	Years	Months	Days	If LESS than 1 day,
	63	8	—	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Knox Co. Mo.

PARENTS

10. NAME OF FATHER — — — —
11. BIRTHPLACE OF FATHER (city or town) (State or Country) — — —
12. MAIDEN NAME OF MOTHER — — — —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) — — — —

14. Informant L. Lund
(Address) Orofino

15. Filed Dec 23, 1929 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1929, to Dec 23, 1929
that I last saw h[illegible] alive on Dec. 22, 1929
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:

Carcinoma of stomach + liver

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) R. J. Hoffman, M. D.
12/24, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Dec 24 1929
20. Undertaker	**Address**
W. A. Shaw	Orofino

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68726

Registration District No. 10
Primary Registration District No. 2187
Local Registrar's No. 115

149

PLACE OF DEATH

County of Clearwater
City of Orofino
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucile Matson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white.	married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of wife of Edward Matson

6. DATE OF BIRTH (month, day and year) June 18 1909.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	6	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10. NAME OF FATHER Chas. Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Edward Matson
(Address) Orofino

15. Filed Jan 23, 1929 H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1929, to Dec. 22, 1929
that I last saw her alive on Dec. 22, 1929
and that death occurred, on the date stated above, at 7:50 a.m.
The CAUSE OF DEATH* was as follows:

Child-birth

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Septicemia puerperal
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. J. Hollens, M. D.
12/24, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gilbert Ida	Jan 26 1929
20. Undertaker	Address
H. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68727

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 114

PLACE OF DEATH

County of Clearwater
City of Orofino
(No. 143)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lenard H. Hanson

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 29 1908

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work machinc
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Farther H. P. Hanson

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Petter Hanson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn
12. MAIDEN NAME OF MOTHER Minnie Hanson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant H. P. Hanson
(Address) Orofino Ida

15. Filed Dec 21, 1929. H. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 21 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 12 noon/night m.
The CAUSE OF DEATH* was as follows:

Accidental Shot with 22 rifle
Bullet going through the brain
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) H. A. Shaw Coroner, M. D.
Dec 21, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino	Dec 23 19
20. Undertaker	**Address**
H. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68728

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 113

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

105

2. FULL NAME Andrew Nelson
(a) Residence. No. Nelson Hospital St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About Years 68 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): ?

PARENTS
10. NAME OF FATHER: ?
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ?
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

14. Informant: Nelson Hospital
(Address) Orofino

15. Filed Dec 14, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2, 1929, to Aug 2, 1929
that I last saw him alive on August 2, 1929
and that death occurred, on the date stated above, at 6.30 A m.
The CAUSE OF DEATH* was as follows:

Asthma, bronchial
(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis, chronic
or Cystitial (duration) unknown yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) R. T. Hopkins, M. D.
12/13, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino Ida
Date of Burial: Dec 14 19

20. Undertaker: W. A. Shaw
Address: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68729

Local Registrar's No. 112

PLACE OF DEATH

County of Clearwater
City of Pierce
Registration District No. 10
Primary Registration District No. 2187
(No.)
(If death occurred in a hospital or institution, give its *name* instead of street and number.)

2. FULL NAME Summer Regdon

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 70			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missiouri

PARENTS

10. NAME OF FATHER ?
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ?
12. MAIDEN NAME OF MOTHER ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ?

14. Informant W. A. Shaw Coroner
(Address) Orofino

15. Filed Dec 10, 1929. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 8 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:

Found dead sitting in chair

Valvar Heart Disease (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. A. Shaw Coroner, M. D.
Dec 9, 1929 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pierce Ida	Dec 11 1929
20. Undertaker	Address
W. A. Shaw	Orofino

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68730

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2187

Local Registrar's No. 111

(No. 117)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harvey Tibbets

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Stella Tibbet

6. DATE OF BIRTH (month, day and year): July 30 1894

7. AGE: Years 35 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laundryman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: North Ida Sanituram

9. BIRTHPLACE (city or town) (State or country): Neb

PARENTS

10. NAME OF FATHER: John Tibbet

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Jennie Curry

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Minn

14. Informant: R. Tibbets
(Address): Orofino Ida

15. Filed Dec 3, 1929. W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1929, to Dec. 2, 1929
that I last saw him alive on Dec. 2, 1929
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:

Acute appendicitis

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Acute peritonitis

(duration) ..... yrs. ..... mos. 4 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 30, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) R. J. Hopkins M. D.

Dec. 2, 1929 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	Dec 6 1929
20. Undertaker	Address
W. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68731

PLACE OF DEATH
County of Custer
City of Clayton

Registration District No. 108
Primary Registration District No. 2186
Local Registrar's No. 95

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Benjamin Worthington

(a) Residence. No. ..... Clayton Idaho ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed or divorced
HUSBAND of (or) WIFE of Ella Worthington

6. DATE OF BIRTH (month, day and year) April 8, 1855

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74 yrs.	8	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberman and Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant L B Worthington
(Address) Clayton Idaho

15. Filed Dec. 7, 1929 Edna McKenney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/7, 1929, to 11/20, 1929
that I last saw h[illegible] alive on 12/1, 1929
and that death occurred, on the date stated above, at 6:10 [illegible] m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) C. L. Hurley M. D.
12/7, 1929 (Address) Challis Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clayton Idaho	Dec. 7, 1929
20. Undertaker Theo R Garner	Address Mackay Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

RECEIVED JAN 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68732

PLACE OF DEATH
County of Custer
City of Mackay

Registration District No. 16
Primary Registration District No. 2153
Local Registrar's No. 125

(No.) 24
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Everett Briggs

(a) Residence. No. Elgin Oregon St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	wt	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 30 1909

7. AGE	Years	Months	Days	If LESS than 1 day,
	20	8	25	X hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer X

9. BIRTHPLACE (city or town) (State or country) Elgin, Oregon

PARENTS

10. NAME OF FATHER Alburtus Briggs
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minnesota
12. MAIDEN NAME OF MOTHER Ollie V. Barnes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Elgin, Oregon

14. Informant Mrs. G. Briggs
(Address) Elgin Oregon

15. Filed 1/11, 1930 Rose Monroe
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 25 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/19, 19 29, to 12/25, 19 29
that I last saw h— alive on 12/25, 19 29
and that death occurred, on the date stated above, at 6:15 A m.
The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis (epid)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Conrad G Jensen, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mackay, Idaho	Dec 29 1929
20. Undertaker	Address
Geo. R. Lannin	Mackay, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68733

PLACE OF DEATH
County of Custer
City of Mackay

Registration District No. 16
Primary Registration District No. 2153
Local Registrar's No. 24

(No. 124.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Howard Milton Sherry 24

(a) Residence. No. Mackay St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wt	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Jan. 22 - 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	11		X hrs. or X min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer X

9. BIRTHPLACE (city or town) (State or country) Mackay, Idaho

PARENTS

10. NAME OF FATHER Raymond E. Sherry
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denver Colorado
12. MAIDEN NAME OF MOTHER Mable Lucile Stratton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mackay

14. Informant Raymond E. Sherry
(Address)

15. Filed 1/11, 1930 Rose Nonnoch
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/22, 1929, to 12/22, 1929, that I last saw h— alive on 12/22/29, 19, and that death occurred, on the date stated above, at 4 20 m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis (Epidemic)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Lab.

(Signed) Cordelia Jensen M. D.
, 19 (Address) Mackay

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. View Cem. Mackay, Idaho	Jan. 23 1929
20. Undertaker Geo. R. Garner	Address Mackay

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68734

PLACE OF DEATH

County of Custer
City of Mackay

CERTIFICATE OF DEATH

Registration District No. 76
Primary Registration District No. 2153
(No.) Local Registrar's No. 123
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME ALVOR C THOMPSON

44

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M
4 COLOR OR RACE: W
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Hannah Thompson

6 DATE OF BIRTH (month, day and year): Nov 6, 1868

7 AGE: Years 61 | Months 1 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Own

9 BIRTHPLACE (city or town) (State or country): Denmark

PARENTS
10 NAME OF FATHER: Jens Thompson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Denmark
12 MAIDEN NAME OF MOTHER: Hannah Jensen
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Denmark

14 Informant: Mrs A C Thompson
(Address)

15 Filed 1/11, 1930 Rose Nowacki Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December (Month) 31 (Day) 1929 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 11/30/29, 19 12/31/29, 19
that I last saw him alive on 12/31/29, 19
and that death occurred, on the date stated above, at 10PM m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Inanition from disease
(duration) - yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy
(Signed) F. P. Richards, M. D.
12/12/29, 19 (Address) Mackay, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Mt Pleasant Utah
Date of Burial: x 19

20. Undertaker: Geo. R. Garnin
Address: Mackay, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68735

PLACE OF DEATH
County of Custer
City of Mackay

Registration District No. 76
Primary Registration District No. 2153

Local Registrar's No. 122

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Anna O Lucini

(a) Residence. No. Mackay St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	wht	Married

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Paul O Lucini

6. DATE OF BIRTH (month, day and year) July 26 1870

7. AGE Years	Months	Days	If LESS than 1 day,
59	~~5~~ 4	3	X hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Persuis, Austria

PARENTS

10. NAME OF FATHER Jack Rukavina

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Austria

12. MAIDEN NAME OF MOTHER X

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Austria

14. Informant X Mary O Lucini
(Address)

15. Filed 1/11, 1930 Rose Nowack
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 - 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-25, 1929, to 11-28, 1929
that I last saw her alive on 11-29, 1929
and that death occurred, on the date stated above, at ~~1~~ P. m.
The CAUSE OF DEATH* was as follows:

Fatty degeneration of Heart
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Carroll A Pearson M. D.
, 19 (Address) Mackay Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mackay Idaho	Nov. 30 1929
20. Undertaker	Address
Theo. P. Garmin	Mackay Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19. RECEIVED JAN 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Mt. Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34

Primary Registration District No. 2020

(No. ..... St.)

File No. 68736

Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Madden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 24th (Day) 1858 (Year)

7. AGE: 71 Yrs. 5 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cardiff Wales

10. NAME OF FATHER: William Chapel

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. H. R. Reed

(Address) Mt. Home, Idaho

15. Filed Dec 28 1929 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1927, to Dec 15 1929 that I last saw her alive on Dec 15 1929 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Endocardidis,

(Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Myocardidis + arteriosclerosis (Duration) 10 yrs. ..... mos. ..... ds.

(Signed) O. P. Hamilton M. D.

12-17 1929 (Address) Mountain Home, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt. Home Ida. DATE OF BURIAL: 12-18 1929

20. UNDERTAKER: G. C. Zacher ADDRESS: Mt. Home Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. RECEIVED JAN 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 68737
Registered No. 21

1. PLACE OF DEATH
County of Elmore
City of Mt. Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tom Yow
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: Chinese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 94 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Jennie Sagey
(Address) Mt. Home Idaho

15. Filed Dec 28 1929
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 11th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1929 to Dec 11 1929
that I last saw him alive on Dec 11 1929
and that death occurred on the date stated above, at 10.20 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia — bilateral

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. S. Hamilton M. D.
12-11 1929 (Address) Mountain Home, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Mt. Home Idaho — DATE OF BURIAL: 12-13 1929

20. UNDERTAKER: E. S. Parker. — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED DEC 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68738

PLACE OF DEATH
County of Elmore
City of Glenns Ferry
Registration District No. 35
Primary Registration District No. 2021
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Abram Thomson White 740

(a) Residence. No. Glenns Ferry St. Idaho
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Susie E. White

6. DATE OF BIRTH (month, day and year) 5-18-1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	5	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER Bundy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Paul L. White
(Address)

15. Filed 11-5, 1929 Mrs Mary Sullivan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1927, to Nov 2, 1929
that I last saw h~~im~~ alive on Nov 2, 1929
and that death occurred, on the date stated above, at 11 07 p m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? What test confirmed diagnosis? Clinical

(Signed) J. W. Davis, M. D.
Nov 4, 1929 (Address) Glenns Ferry

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or~~ Removal	Date of Burial
Tekamah Nebr	11-7 1929

20. Undertaker G. C. Zacher Address Glenns Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REC... JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68739

PLACE OF DEATH

County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Jane Willmore

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Earnest Willmore

6. DATE OF BIRTH (month, day and year) Aug 4 1879

7. AGE	Years	Months	Days	If LESS than 1 day,
	50	4	26	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Logan Utah

PARENTS

10. NAME OF FATHER Benjiman Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Mary Ann Nelson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Farmington Utah

14. Informant Earnest Alfred Williams
(Address) Preston Idaho

15. Filed Jan 2, 1930 A. P. Oelle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1927, to Dec 30, 1929
that I last saw her alive on Dec 30, 1929
and that death occurred, on the date stated above, at 9 30 a.m.
The CAUSE OF DEATH* was as follows:
Chronic interstitial Nephritis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Endocarditis
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) E S Guilford M. D.
, 19 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Preston Idaho | Date of Burial Jan. 2 30 19

20. Undertaker M. W. Hendricks | Address Preston Idaho

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6874 0

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Issac Lacy Bennett

(a) Residence. No. Preston Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

131

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widdowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nancy Jane Bennett

6. DATE OF BIRTH (month, day and year) Sept 23 1853

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	3		

8. OCCUPATION OF DECEASED Farmer

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Thomas B. Bennett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Ann Lacy Bennett

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Frank Merrill

(Address) Preston Idaho

15. Filed Dec-26, 1929 A. R. Neeley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 25 1929, to Dec 24 1929, that I last saw h[illegible] alive on Dec 24 1929, and that death occurred, on the date stated above, at 7 40 p m.

The CAUSE OF DEATH* was as follows:

Trauma following fractured thigh and pelvis from fall on ice -

(duration) 4 yrs. 1 mos. 30 ds.

CONTRIBUTORY (Secondary) Senile debility from age

(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of Nov. 25-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. W. Stites, M. D.

Dec. 25, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Dec 27 29 19

20. Undertaker Hendricks Address Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68741

PLACE OF DEATH

County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

164

2. FULL NAME Ella Christena Harrington

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Harrington

6. DATE OF BIRTH (month, day and year) Sept 23 1846 dont

7. AGE

Years	Months	Days	If LESS than 1 day,
About 83	Eighty Years		hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or State or Country) England

14. Informant Mrs J.A.Paton
(Address) Preston

15. Filed Dec 30, 1929 A. R. Allen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
know last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

General Causes
due to old age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] Coroner, M. D.

Dec 30, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Dec. 30 19

20. Undertaker	Address
M W .Hendricks	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68742

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Carter

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 6 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
			2	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work BABY

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston Idaho

PARENTS

10. NAME OF FATHER Earnest W. Carter

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden Utah

12. MAIDEN NAME OF MOTHER Anna L. Pettersen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Glendale Idaho

14. Informant Earnest W. Carter

(Address) Preston Idaho

15. Filed Dec. 10, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6, 1929, to Dec 6, 1929
that I last saw him alive on Dec 7, 1929
and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Congenital Heart disease

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. W. Stalen, M. D.

Dec 8, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Id ho	Dec 9 m 29

20. Undertaker M. W. Hendricks Address Prston

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68743

PLACE OF DEATH
County of Franklin
City of Fairview
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No.
(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Mathew Johnson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jand Gilbert Johnson

6. DATE OF BIRTH (month, day and year) May 25 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	6	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) London England
(State or country)

PARENTS

10. NAME OF FATHER UNKNOWN
11. BIRTHPLACE OF FATHER (city or town) England
(State or Country)
12. MAIDEN NAME OF MOTHER UNKNOWN
13. BIRTHPLACE OF MOTHER (city or town) ENGLAND
(State or Country)

14. Informant Eliga Gilbert
(Address) Fairview Idaho

15. Filed Dec 11, 1929 C. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-1, 1929, to 12-10, 1929
that I last saw h[illegible] alive on 12-3, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis - Uremia.
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Hypertrophy of Prostate
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. R. Cutler, M. D.
Dec. 11, 1929 (Address) Fairview Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fairview Idaho	Dec. 12 19
20. Undertaker	Address
M.W.Hendricks	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68746

PLACE OF DEATH

County of Franklin
City of Mapleton
Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Howard Porter Knapp

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

37

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept I3 I927

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	3	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Mapleton

PARENTS

10. NAME OF FATHER: Henry W. Knapp
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wisconsin
12. MAIDEN NAME OF MOTHER: Cora Porter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mapleton Idaho

14. Informant: Henry W. Knapp
(Address): Mapleton Idaho

15. Filed Dec. 17, 1929. A. R. Outlaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) - 15 (Day) - 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to Dec - 15 , 1929
that I last saw him alive on Dec 13 - , 1929
and that death occurred, on the date stated above, at 5-30 p m.
The CAUSE OF DEATH* was as follows:
Tuberculous Meningitis following a general Miliary tuberculosis

(duration) yrs. 4 mos. ds.
CONTRIBUTORY (Secondary) Whooping Cough 4 months
Bronco (duration) - yrs. 4 mos. - ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) G. W. States, M. D.
Dec 16 - , 1929 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Franklin Idaho — Date of Burial: Dec. I7 1929

20. Undertaker: M. W. Hendricks — Address: Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 6 1930

PLACE OF DEATH
Franklin
County of .....
City of Preston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. .....
Primary Registration District No. .....

DO NOT WRITE IN THIS SPACE
State File No. 68747

Local Registrar's No. .....

(No. 44 .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Benjaman Geo. Dunkley
(a) Residence. No. ..... Preston Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Susan Dunkley

6. DATE OF BIRTH (month, day and year): May 10 1874

7. AGE: Years 55 | Months 7 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer and Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Franklin Idaho

PARENTS

10. NAME OF FATHER: Joseph Dunkley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Margurett Wright
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: Mrs Susan Dunkley
(Address): Preston Idaho

15. Filed Dec 24, 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 - 1929, to Dec 21, 1929
that I last saw him alive on Dec 20, 1929
and that death occurred, on the date stated above, at 3 30 p m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) 1 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Gastric ulcer
(duration) 3 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of Nov-1929
Was there an autopsy? no
What test confirmed diagnosis? Clinical & operative
(Signed) G W. Staten, M. D.
Dec 22 1929 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Whitney, Idaho	Dec 23 19 29
20. Undertaker: M. W. Hendricks	Address: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECE... JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68748

PLACE OF DEATH
County of Franklin
City of Franklin

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

162

2. FULL NAME Nina Peterson
(a) Residence. No. Franklin St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec. 14 1929
7. AGE Years Months Days 9 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED ✓
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Franklin Ida

PARENTS
10. NAME OF FATHER O L Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Franklin Idaho
12. MAIDEN NAME OF MOTHER Leona Beckstead
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Ogden Idah

14. Informant Leo Peterson
(Address) Franklin Ida

15. Filed Dec. 24, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Dec 22, 1929
that I last saw her alive on Dec 22, 1929
and that death occurred, on the date stated above, at 1 10 P m.
The CAUSE OF DEATH* was as follows:
Foraman Ovale failed to close
(duration) yrs. mos. 9 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W B Parkinson M. D.
Dec 22, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Whitney Ida
Date of Burial: Dec 23 1929
20. Undertaker: M W Hendricks
Address: Preston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68749

PLACE OF DEATH
County of Franklin
City of Preston, Ida

Registration District No. 27
Primary Registration District No. 2119
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

205-A

2. FULL NAME Theone Bodily
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Dec. 8, 1929

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days: 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: baby
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Fairview Idaho

PARENTS

10. NAME OF FATHER: George Clarence Bodily
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Fairview Ida
12. MAIDEN NAME OF MOTHER: Florence Louis Orchard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Lewiston, Utah

14. Informant: George C Bodily
(Address): Preston Ida Route #3

15. Filed Dec. 19, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 19 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Asphyxia
Mother laid on child
..... (duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) ....., M. D.
Dec. 19, 1929 (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fairview, Idaho | Date of Burial: Dec. 20 1929

20. Undertaker | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

PLACE OF DEATH

County of Franklin

City of preston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68750

Local Registrar's No.

117

2. FULL NAME Franklin J. Cox

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Apr 18 1924

7. AGE: Years 5, Months 8, Days 2. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED: BABY

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ogden Utah

PARENTS

10. NAME OF FATHER: Orson F. Cox

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Milburn Utah

12. MAIDEN NAME OF MOTHER: AltheaBM Hobson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): SwanLake Idaho

14. Informant: Orson F. Cox
(Address) Oxford Idaho

15. Filed Dec. 24, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15th, 1929, to Dec 20, 1929

that I last saw him alive on Dec 20, 1929

and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

Dec. 21, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Swanlake Idaho

Date of Burial: Dec 23 1929

20. Undertaker: MW Hendricks

Address: Preston Idaho

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68751

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Austin WM. Merrill

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarrah Merrill

6. DATE OF BIRTH (month, day and year) May 7 1862/ 1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60 6/1	7	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Smithfield Utah

PARENTS

10. NAME OF FATHER Austin T. Merrill

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Mary Jane Merrill

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Sarrah Merrill
(Address) Preston Idaho

15. Filed Jan 2, 1930 A. C. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6, 1929, to Dec 30, 1929
that I last saw him alive on Dec 30, 1929
and that death occurred, on the date stated above, at 10a m.
The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 2 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Gastritis Ulcer
(duration) 8 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Not to my knowledge
Did an operation precede death? Date of Not to my knowledge
Was there an autopsy? No
What test confirmed diagnosis? Observed
(Signed) G. W. Sales, M. D.
Dec 31, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Smithfield Utah	Jan 2 30 19

20. Undertaker M/. W Hendricks
Address Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68752

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Peter J. Moore

(a) Residence. No. 119 North 1st West St. 122
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret A. Moore

6. DATE OF BIRTH (month, day and year) 5-7-1859

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~70~~	70	7	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Liverpool, Eng.

PARENTS

10. NAME OF FATHER Peter Moore

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Liverpool, Eng.

12. MAIDEN NAME OF MOTHER Margaret Frew

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Franklin Co. Ida.

14. Informant Weldon Moore
(Address) Preston Ida

15. Filed Dec. 31, 1929 C. R. Butler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1925, to 12-29, 1929
that I last saw him alive on 12-28, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
~~Cancer~~ Cirrhosis of the liver

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Appy
(Signed) E. S. Mitchell, M. D.
12-31, 1929 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Ida	12-31-1929
20. Undertaker M. W. Hendricks	Address Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6875 3

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Lafayette Hyde

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OF RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Jennie Hyde

6. DATE OF BIRTH (month, day and year) Feb 13 - 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	10	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10. NAME OF FATHER John A. Hyde
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Louisa Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn

14. Informant Ind Hyde
(Address) Emmett Idaho

15. Filed 12/19, 1929 J K Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
several years, to Dec 17, 1929
that I last saw him alive on Dec 17, 1929
and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:
Chronic Cystitis Suppurative
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J C Reynolds M. D.
12/19, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	12/19 1929

20. Undertaker O D Beckner Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68754

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. 6
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME William A. Matthews

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Caroline Matthews

6. DATE OF BIRTH (month, day and year) Oct 26 - 1852

7. AGE Years 77 Months 2 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Syracuse N. Y.

PARENTS
10. NAME OF FATHER Ichabod Matthews
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Elizabeth Martin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Belfast Ireland

14. Informant Caroline Matthews
(Address) Emmett

15. Filed 1/2, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-13-, 1929, to Nov 15, 1929
that I last saw him alive on Nov 15, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Inanition? - Following sloughing of parts about the Caecum due to a thrombosis of a small mesenteric artery
(duration) yrs. 1½ mos. ds.
CONTRIBUTORY (Secondary) arterio sclerosis
(duration) several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 11-15-29
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [illegible], M. D.
1/2, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rexburg Idaho
Date of Burial 19

20. Undertaker C D Bucknum
Address Emmett Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68755

PLACE OF DEATH
County of Ada
City of Emmett

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Frank Porter

(a) Residence. No. 6 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 11 1908

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	7	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lawrence Kansas

PARENTS

10. NAME OF FATHER Frank M. Porter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Louisa M. Roland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Roy M. Porter
(Address) Emmett Idaho

15. Filed 11/25, 1929 J. K. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 18, 1929, to Nov 24, 1929
that I last saw ~~him~~ alive on Nov 14, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
(duration) yrs. mos. 4 ds.
CONTRIBUTORY none
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Salmon river Country
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Widal
(Signed) R. M. Emmett, M. D.
11/25 1929 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Ida	11/26 1929

20. Undertaker C. D. Buckmun — Address Emmett Idaho

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 4 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 68756

Registered No. .....

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

County of Ada

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary McClurg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. Sept (Month) 6 (Day) 1908 (Year)

7. AGE: 21 Yrs. 3 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Joseph Emerick

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Lizzie Herriek

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Emerick

(Address) Cle Elum, Wash

15.

Filed 12/17 1929

J. C. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Probably from burns in an
Automobile fire

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Watkins Coroner M. D.

12/17 1929 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cle Elum, Wash

DATE OF BURIAL ..... 191...

20. UNDERTAKER: C. A. Buckmaster

ADDRESS Emmett Idaho

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 4 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Gem

City of Emmett

Registration District No.

Primary Registration District No. 6

(No. , St.)

File No. 68757

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Lucinda Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. Mar (Month) 21 (Day) 1836 (Year)

7. AGE 93 Yrs. 8 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER James Leach

11. BIRTHPLACE OF FATHER (State or Country) Mass.

12. MAIDEN NAME OF MOTHER Minerva Benton

13. BIRTHPLACE OF MOTHER (State or Country) Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie B Jones

(Address) Emmett Idaho

15. Filed 12/17 1929

J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

129

16. DATE OF DEATH Dec (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1929, to Dec 15 1929, that I last saw her alive on Dec 14 1929, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Uremia

Chronic nephritis

(Duration) ..... Yrs. ..... mos. three ds.

Contributory (Secondary) old age

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Reynolds M. D.

12/17 1929 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Anoka, Minn

DATE OF BURIAL 191

20. UNDERTAKER: C D Bucknum

ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SGRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 4 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Emmett

City of Ilem

Registration District No.

Primary Registration District No.

(No. ..... St.)

File No. 68758

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie Snyder Wentworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept (Month) 4 (Day) 1885 (Year)

7. AGE 44 Yrs. 3 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)... Kansas

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Alvin Snyder

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Melissa J. Burger

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R B Wentworth

(Address) Emmett Idaho

15. Filed 12/17 1929 J L Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 16 (Day) 1929 (Year) 101 B

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1929, to Dec 16 1929, that I last saw her alive on Dec 15 1929, and that death occured on the date stated above, at 7-40 A.M.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Influenza

(Duration ..... yrs. ..... mos. 3 ds.

(Signed) J L Reynolds M. D.

12/17 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Seneca, Kansas

DATE OF BURIAL 191

20. UNDERTAKER: C D Bucknum

ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 4 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 68759

Registered No. .....

1. PLACE OF DEATH.

County of Gem

City of Emmett

Registration District No. .....

Primary Registration District No. 6

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Thomas Wander

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): infant

6. DATE OF BIRTH. Feb (Month) 22 (Day) 1929 (Year)

7. AGE ..... Yrs. 9 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Harry Wander

11. BIRTHPLACE OF FATHER (State or Country) Holland

12. MAIDEN NAME OF MOTHER Frances Konoske

13. BIRTHPLACE OF MOTHER (State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Wander

(Address) Emmett Idaho

15. Filed 12/4 1929 J K Reynolds Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 3 (Day) 1929 (Year)

10A

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1929, to Dec. 3 1929, that I last saw him alive on Dec. 3 1929, and that death occured on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

Probable (Duration) — Yrs. — mos. 9 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Harrison D Freeman M. D.

12/4 1929 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Emmett Ida — DATE OF BURIAL Dec 5 1929

20. UNDERTAKER C D Buckner — ADDRESS Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 4 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 6

(No. , St.)

File No. 68760

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tessie Irena Coleman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH. May (Month) 2 (Day) 1899 (Year)

7. AGE 30 Yrs. 7 Mos. 13 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Arkansas

10. NAME OF FATHER Hiram L. Littell

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Sylvia C. Belville

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. K. Coleman

(Address) Emmett Idaho

15. Filed 12/16 1929 J. K. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

101B

16. DATE OF DEATH Dec (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-10 1929, to 12-15- 1929, that I last saw her alive on 12-14- 1929, and that death occured on the date stated above, at 4-30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary) Influenza

(Duration yrs. mos. 2 ds.

(Signed) J. K. Reynolds M. D.

12/16 1929 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Caldwell Idaho

DATE OF BURIAL 191

20. UNDERTAKER C. D. Bucknum

ADDRESS Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 24654

FORM V. REC 1-25 M 1-29. JAN 8 1930

CERTIFICATE OF DEATH

Registration District No. 24

Primary Registration District No.

(No. , St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6876

Registered No. 113

1. PLACE OF DEATH

County of Gooding

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Unnamed) Clepper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: Dec (Month) 1 (Day) 1929 (Year)

7. AGE: ....Yrs....Mos....ds. IF LESS than 1 day how many 21 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gooding Idaho

10. NAME OF FATHER: Clarence R. Clepper

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Muriel Ravencroft

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C R Clepper
(Address) Hazelton Ida

15. Filed 12/31 1929 J H Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-1 1929, to 12-2 1929, that I last saw h alive on 12-2 1929, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Congested heart disease
(Blue baby)

(Duration) ....Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J H Cromwell M. D.

12/2 1929 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gooding Ida	12/3 1929

20. UNDERTAKER	ADDRESS
A E Thompson	Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 68762

PLACE OF DEATH

County of Gooding

City of "

CERTIFICATE OF DEATH

Registration District No. 24

Primary Registration District No.

(No.)

Local Registrar's No. 114

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. **FULL NAME** Sam Lewis.

(a) Residence. No. Gooding Idah St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: 73 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rochester N.Y.

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Frank Lewis.
(Address)

15 Filed 12-31, 1929 J H Cromwell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December (Month) 27 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 11-30, 1929, to 12-27, 1929, that I last saw him alive on 12-27, 1929, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease

(duration) 7 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J H Cromwell M. D.

12/28, 1929 (Address) Gooding Idah

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, ~~Cremation, or Removal~~: Gooding Idah

Date of Burial: 12-29 1929

20. Undertaker: A E Thompson

Address: Gooding

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

REGISTERED JAN 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of "

Registration District No. 24

Primary Registration District No.

(No. ..... St.)

File No. 6876

Registered No. 115

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Crow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	~~Married~~

6. DATE OF BIRTH: Dec (Month) 6 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gooding Ida

10. NAME OF FATHER: Chas F Crow

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Edelin Christopherson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas Crow

(Address) Gooding Ida

15. Filed 12/30 1929 J H Cromwell, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 13th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-6- 1929, to 12-13- 1929, that I last saw h[illegible] alive on 12-13- 1929, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Erysipelas of face

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Cromwell M. D.

12/13 1929 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida — DATE OF BURIAL: 12/14 1929

20. UNDERTAKER: A E Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68764

PLACE OF DEATH
County of Gooding
City of "

Registration District No.
Primary Registration District No. 24
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 116

2. FULL NAME Lucinda Powell

(a) Residence. No. Gooding Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

24a

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J W Powell

6 DATE OF BIRTH (month, day and year): Jun 28

7 AGE: Years 78 | Months 6 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Iowa Marion County

PARENTS
10 NAME OF FATHER: John Stipp
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio 24 1815
12 MAIDEN NAME OF MOTHER: Mary Asher
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fayette [illegible]

14 Informant: Mary M Watson
(Address)

15 Filed 12/30, 1929 J H Cromwell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 22 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929, to Dec 22, 1929, that I last saw her alive on 12-22-, 1929, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Nephritis
(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J H Cromwell M. D.
12/24 1929 (Address) Gooding

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Elmwood Cemetery
Date of Burial: 12/24 1929

20. Undertaker: Gooding A E Thompson
Address: Gooding

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

REC[illegible] JAN 4 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Hagerman

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No.

(No. , St.)

File No. 68765

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rulf Hastings

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: Dec (Month) 23 (Day) 1929 (Year)

7. AGE: 2 days Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Hagerman

10. NAME OF FATHER: John G Hastings

11. BIRTHPLACE OF FATHER (State or Country): Miss

12. MAIDEN NAME OF MOTHER: Zoe M Kennicott

13. BIRTHPLACE OF MOTHER (State or Country): Chicago Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Hastings

(Address) Hagerman

15. Filed Dec 24 1929

R H Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1929 (Year)

16a

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1929, to Dec 23 1929, that I last saw him alive on Dec 23 1929, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Premature birth

X

(Duration) Yrs. mos. ds.

Contributory (Secondary) Weak Vitality

(Duration) yrs. mos. ds.

(Signed) R H Greene M. D.

Dec 24 1929 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hagerman

DATE OF BURIAL: Dec 24 1929

20. UNDERTAKER: None

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 4 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Hagerman

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 21

(No. , St.)

File No. 68766

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Joseph Cortner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 3 (Day) 1854 (Year)

7. AGE: 75 Yrs. 4 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Andrew Cortner

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Ford

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Cortner

(Address) Hagerman

15. Filed Oct 1 1929

R H Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 1 (Day) 1929 (Year) 90

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,

that I last saw h..... alive on ..... 19...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Saw him after death.
Found dead in bed.
Organic heart trouble

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R H Greene M. D.

Oct 1 1929 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise

DATE OF BURIAL: Oct 4 1929

20. UNDERTAKER: Evelyn A Johnson

ADDRESS: Buhl

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHY[illegible] should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible]TION is very important. See instruction on back of certificate.

JAN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68767

County of Gooding

City of Hagerman Registration District No. ..... Local Registrar's No. 21

Primary Registration District No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Mary Elizabeth Petersen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 2nd 1854

7. AGE

Years	Months	Days	If LESS than 1 day,
74	9	18	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nottingham England

PARENTS

10. NAME OF FATHER Wm Robinson - England

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Mary E. Dexter

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant J E Petersen
(Address) Evanston Wyo

15. Filed Nov 1, 1929. Robt Greene Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-20, 1929, to 9-20, 1929

that I last saw him alive on 9-20, 1929

and that death occurred, on the date stated above, at 10:30 P.m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

..... (duration) Died instantly yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Geo Jennings, M. D.

9-21-, 1929 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hagerman Ida — Date of Burial 9/24 1929

20. Undertaker L Johnson — Address Buhl, Ida

RECEIVED JAN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68763

County of .....
City of .....

Registration District No. 21
Primary Registration District No. .....
(No. .....)

Local Registrar's No. .....

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Harriet R Dudley

(a) Residence. No. Galion Ohio St. 100a
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of Henry E Dudley

6 DATE OF BIRTH (month, day and year): Mar 29 - 1842

7 AGE: ~~87~~ Years 87 Months 7 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House holder
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Galion - Ohio

PARENTS
10 NAME OF FATHER: W. P Harding
11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn.
12 MAIDEN NAME OF MOTHER: Isabinda McGowen
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Y Y

14 Informant: O. L. Dudley
(Address): Wendell - Idaho

15 Filed Nov 7, 1929 R H Greene Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 11 (Month) 7 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1929, to Nov 6, 1929, that I last saw her alive on Nov 6 - 1929, and that death occurred, on the date stated above, at 2 a m. Nov 7 - 1929

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary): Old age -
contracted (duration) Cold 2 weeks before yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) R H Greene M. D.
Nov 7, 1929 (Address) Hagerman Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Galion Ohio Blooming Grove Cemetery
Date of Burial: Ohio 19

20. Undertaker
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 63763

Local Registrar's No. 21

PLACE OF DEATH

County of Bonding

City of Hagerman Registration District No.

Primary Registration District No.

(No. 90)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elijhet M. Bell

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 21 - 1848

7. AGE	Years	Months	Days	If LESS than 1 day,
	80	11	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kentucky
(State or country)

PARENTS

10. NAME OF FATHER James R. Bell

11. BIRTHPLACE OF FATHER (city or town) Kentucky
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Farrow

13. BIRTHPLACE OF MOTHER (city or town) Kentucky
(State or Country)

14. Informant Glenn Bell
(Address)

15. Filed NOV 25, 1929 R H Greene Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14, 1929 to Nov 24, 1929
that I last saw him alive on Nov 20, 1929
and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:
Cardio Vascular renal disease
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Uraemic poisoning
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO Urinalysis
What test confirmed diagnosis? Blood pressure
(Signed) C. L. Dimmitt, M. D.
Nov 26, 1929 (Address) Wendell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hagerman	Nov 26 1929
20. Undertaker	Address
Emerson	Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A-25M. 1-19. RECEIVED JAN 9 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Idaho

City of Stites

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St.)

State File No. 68770

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6. DATE OF BIRTH Feb (Month) 17 (Day) 1915 (Year)

7. AGE 14 Yrs. 9 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kamiah Idaho

10. NAME OF Father Mark Allen

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Edna Newman

13. BIRTHPLACE OF MOTHER (State or Country) Kamiah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edna Newman
(Address) Lapwai Ida

15.
Filed 1929
Local Registrar

MEDICAL CERTIFICATE OF DEATH

188C

16. DATE OF DEATH Nov. (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19...., to ..... 19...., that I last saw h..... alive on ..... 19...., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Crushed skull from Automobile accident happened near Stites Ida on Charmater River

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C A Hancock Corner

Dec 31/1929 (Address) Grangeville Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

REC JAN 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
(No. ..... St.)

File No. 6071
Registered No. 12

1. PLACE OF DEATH

County of Idaho
City of Cottonwood

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Henry Sprute Sr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 17 (Day) 1843 (Year)

7. AGE: 86 Yrs. 3 Mos. 16 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: John Jenewig

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herbert Sprute
(Address) Cottonwood

15. Filed 12/30 1929 H. F. Orr I. B.
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1929, to Dec - 3 1929, that I last saw her alive on Dec - 3 1929, and that death occurred on the date stated above, at 11:40 P M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.
12/4 1929 (Address) Cottonwood Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cottonwood Idaho	12/5 1929
20. UNDERTAKER	**ADDRESS**
Brower & Hann	Lewiston, Ida.

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68772

PLACE OF DEATH
County of Idaho
City of Ferdiand

Registration District No.
Primary Registration District No.
(No. Ranch at Ferdiand)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

11a

2. FULL NAME Herman Herny Arnzen

(a) Residence. No. Ferdiand St.
(Usual place of abode)
Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Bernadina Arnzen

6. DATE OF BIRTH (month, day and year) Nov 27, 1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60		12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illoneis

PARENTS

10. NAME OF FATHER Joseph Arnzen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Bathenami Dretman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illoneis

14. Informant Mrs. Bernadina Arnzen
(Address) Ferdinand, Idaho.

15. Filed 12/30, 1929 W. F. Orr J.B. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1929 to Dec - 8, 1929
that I last saw him alive on Dec 8, 1929
and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:
Influenzal Pneumonia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical only.

(Signed) Verdy F. Orr, M. D.
12/9/29, 19 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ferdiand	12/10 1929
20. Undertaker Vassar	Address Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19 RECEIVED JAN 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Ferdinand

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105

Primary Registration District No. 2183

(No. ..... St.)

File No. 68773

Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Lee Albert Zodrow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: November (Month) 12 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ferdinand Ida

10. NAME OF FATHER Leonard G Zodrow

11. BIRTHPLACE OF FATHER (State or Country) Dresden, Kans.

12. MAIDEN NAME OF MOTHER Leona Knopes

13. BIRTHPLACE OF MOTHER (State or Country) Uniontown Wn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leonard G Zodrow

(Address) Ferdinand Ida.

15. Filed Dec. 30 1929 W. F. Orr Local Registrar

MEDICAL CERTIFICATE OF DEATH

205-B

16. DATE OF DEATH: November (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... , to ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred on the date stated above, at 5:10 P. M.

The CAUSE OF DEATH* was as follows:

No attendance
Cause unknown.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.

12/22 1929 (Address) Cottonwood Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ferdinand Ida.

DATE OF BURIAL: 11/22 1929

20. UNDERTAKER: Father Herman

ADDRESS: Ferdinand, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JAN 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68774

PLACE OF DEATH

County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 45

129

2. FULL NAME Anna Bell Castle

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Levie Castle

6. DATE OF BIRTH (month, day and year) June 4 1869

7. AGE Years 61 Months 6 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer ~~Hanas~~

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Richard N Henley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs W. T. Dinger
(Address) 415-6 Ave. Seattle Wash

15. Filed 1-1- 1930 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929, to Dec 22, 1929
that I last saw her alive on Dec 21, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Organic heart & Nephritis
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J. F. Weber, M. D.
Dec 22, 1929 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville Ida. Date of Burial 12-26- 1929

20. Undertaker Handcock Mndg Co Address Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68775

PLACE OF DEATH
County of Idaho
City of White Bird

Registration District No. 103
Primary Registration District No. 2181
Local Registrar's No. 44

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Elbra M Brown

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 1838

7. AGE Years 92 Months Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ritch Field
(State or country) Summit Co Ohio

PARENTS
10. NAME OF FATHER Markas Milton Brown
11. BIRTHPLACE OF FATHER (city or town) Ohio
(State or Country)
12. MAIDEN NAME OF MOTHER Hanah Fletcher
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant Mrs W. H. Harrison
(Address) Wistaria B.C.

15. Filed 1-1- 1930 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1927, to Nov. 10, 1929
that I last saw her alive on Nov 10, 1929
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Organic Heart lesion

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Heart lesions
(Signed) B Chipman, M. D.
12-31- 1929 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Whitebird Ida
Date of Burial 12-11- 1929

20. Undertaker Hundcock Mndg. Co.
Address Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68776

PLACE OF DEATH
County of Grangeville
City of Idaho

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 43

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

57

2. FULL NAME Julius Van Bargen

(a) Residence. No. Grangeville St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Frieda

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	4	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9. BIRTHPLACE (city or town) Doin Dush
(State or country)

PARENTS

10. NAME OF FATHER Michael Van Bargen
11. BIRTHPLACE OF FATHER (city or town) Doin Dush
(State or Country)
12. MAIDEN NAME OF MOTHER Mark Van Buyen
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant Grangeville Ida.
(Address) Frieda Van Bargen.

15. Filed 1-1-, 1930 D Chapman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to Dec 8, 1929
that I last saw h~~im~~ alive on Dec 7, 1929
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
(duration) 2 yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Urinary findings
(Signed) D Chapman M. D.
12-31-, 1929 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida	12-11-1929

20. Undertaker Hunstock Imd Co. Address Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68777

PLACE OF DEATH
County of Idaho
City of Grangeville
Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 42
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

746

2. FULL NAME Julian Van Horne

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Marie VanHorne

6. DATE OF BIRTH (month, day and year) March 11 1855

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	8	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wis

PARENTS
10. NAME OF FATHER Wm Van Horne
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Mary Block
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Frank Reynolds
(Address) Grangeville Idaho

15. Filed 1-1-1930 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1929, to Dec 10, 1929
that I last saw h.. alive on Dec 10, 1929
and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) ..... yrs. ..... mos. 26 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 5 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Autopsy
(Signed) B. Chipman M. D.
Dec 31, 1929 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida	12-12-1929
20. Undertaker Handcock Mtg. Co.	Address Grangeville Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68778

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 41

2. FULL NAME G E Otis King, Gross Edward
(a) Residence. No. Grangeville St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March

7. AGE Years 18 Months 8 Days 13 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lab
(b) General nature of industry, business, or establishment in which employed (or employer) L
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grangeville

PARENTS
10. NAME OF FATHER George B King
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dayton Wash
12. MAIDEN NAME OF MOTHER Lena Gross
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Geo V Ring Father
(Address) 412-S-Hall St Grangeville Id.

15. Filed 1-1-, 1930 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13, 1929, to Nov 29, 1929
that I last saw him alive on Nov 29, 1929
and that death occurred, on the date stated above, at 2 20 a m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(duration) 1 yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Scarlet Fever
1927. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J D Thinnick, M. D.
Dec 5, 1929 (Address) Grangeville, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville Ida. Date of Burial 12-1- 1929

20. Undertaker Hundcock Mudg. Co. Address Grangeville Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68780

PLACE OF DEATH
County of Idaho
City of
Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No. 285

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Not named - 16th

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year): Nov 4-1929

7 AGE: Years | Months | Days | If LESS than 1 day ... hrs. or 30 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Stites Idaho

PARENTS
10 NAME OF FATHER: Louis A Hall.
11 BIRTHPLACE OF FATHER (city or town) (State or country): Dayton Wash
12 MAIDEN NAME OF MOTHER: Maude Cummings
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sonchet Wash.

14 Informant: Louis A. Hall
(Address): Stites Idaho

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 4 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1929, to Nov 4, 1929
that I last saw h. SW alive on Nov 4 1929
and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:
Premature infant - 6 months foetus
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H W Wentworth, M. D.
Nov 30, 1929 (Address) Stites Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECORDED DEC 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68781

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
Local Registrar's No. 284

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

71B

2. FULL NAME James William Decker

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July-31-1926

7. AGE: Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kooskia-Idaho

PARENTS

10. NAME OF FATHER: George Decker
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Michigan
12. MAIDEN NAME OF MOTHER: Lulu Billups.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kansas

14. Informant: Lulu Decker
(Address): Kooskia-Idaho

15. Filed Oct-18, 1929 J M Verberkmoes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct- (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-17, 1929, to Oct-17, 1929
that I last saw him alive on Oct-17, 1929
and that death occurred, on the date stated above, at 2:30 p.m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J.M. Verberkmoes, M. D.
Oct-18, 1929 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kooskia-Cemetery
Date of Burial: Oct-19 1929

20. Undertaker: Geo Frenary
Address: Kooskia-Idaho

RECEIVED DEC 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 68782

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Idaho

City of Stites

Registration District No.

Primary Registration District No.

(No.)

Local Registrar's No. 283

131

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Leland Lake Emmert

(a) Residence. No. Main St. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Emmert

6 DATE OF BIRTH (month, day and year)

7 AGE Years 27 Months Days 11 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Clearwater Ida

PARENTS

10 NAME OF FATHER George Emmert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Iowa - Dubuque

12 MAIDEN NAME OF MOTHER Alva Manes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Oklahoma

14 Informant Clifford A. Emmert

(Address) Stites Ida

15 Filed Oct-11, 1929 J M Verbeekmoes Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 9th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 9th, 1929, that I last saw him alive on Oct 8th, 1929, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows: Acute exacerbation of chronic Brights

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History Urinary tests

(Signed) H W W Smithworth, M. D.

Oct 9, 1929 (Address) Stites

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Clearwater

Date of Burial Oct 10 1929

20. Undertaker

Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68783

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 282

100a

2. FULL NAME Martha Yellow Bear

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Indian
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Yellow Bear

6. DATE OF BIRTH (month, day and year) about - 97 years

7. AGE Years Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER ~~Not of~~ Penakalentimiset

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Peoproplin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Nancy Parsons
(Address) Kooskia - Idaho

15. Filed Oct-9, 1929 J M Verbeekmans Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-4, 1929, to Oct 8, 1929
that I last saw her alive on Oct-7, 1929
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:

Broncho pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J M. Verbeekmans M. D.
Oct-9, 1929 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal First Church - Kamiah
Date of Burial 19

20. Undertaker
Address

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68784

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2176
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME John Henry McNulty
(a) Residence. No. near Rigby Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 10 1859.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Vermont

PARENTS

10. NAME OF FATHER: McNulty
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Kate Cassidy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Mrs. Jno H McNulty
(Address): Rigby Ida

15. Filed 11-1, 19 29 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 26 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Dan T. Pride, M. D.
, 19 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	Oct 26. 1929
20. Undertaker	Address
Cliff Hayes	Idaho Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 19 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68786

County of Jefferson
City of Rigby
Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

21

2. FULL NAME Lona Fay Lessey.

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Child.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6. DATE OF BIRTH (month, day and year) Feb. 10, 1926

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	5	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Rigby, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Chester Richard Lessey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.
12. MAIDEN NAME OF MOTHER Annetta Udy.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant C R Lessey
(Address) Rigby, Idaho.

15. Filed 11-1, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7th, 1929, to July 10th, 1929
that I last saw her alive on July 10th, 1929
and that death occurred, on the date stated above, at 5-30 A.M.

The CAUSE OF DEATH* was as follows:
Erysipelas
Acute General Sepsis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) W. A. Anderson, M. D.
July 11th, 1929 (Address) Rigby, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Rigby, Idaho.	

20. Undertaker C B Eckersell Address Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 19 1929

PLACE OF DEATH

County of Jefferson.

City of Ririe

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78

Primary Registration District No. 2176

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68787

Local Registrar's No. .....

90

2. FULL NAME Clara Caldonia Clark

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. M.

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of John E. Clark.

6. DATE OF BIRTH (month, day and year) Sept. 5, 1868

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60	7	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER Gabriel Lowder.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia.

12. MAIDEN NAME OF MOTHER Harriett Hennigar.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia.

14. Informant John E. Clark

(Address) Ririe, Idaho.

15. Filed 11-1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 24 (Day) 1929 (Year) 19..

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 19.., to April 23, 19.. that I last saw her alive on April 23, 19.. and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Structural Heart Disease

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Don't know

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Sam F. Price M. D.

....., 19.. (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby, Idaho.

Date of Burial: 4/27 192..

20. Undertaker: [signature] Address: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED DEC 19 1929

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68788

PLACE OF DEATH
County of Lorenzo.
City of Lorenzo
Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No. 162
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dail Heman Thomas.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Babe

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 9th, 1928

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Babe
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Roberts, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER William Mead Thomas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.
12. MAIDEN NAME OF MOTHER Josie Deloris Scott
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Mrs Josie F Thomas.
(Address) Lorenzo, Idaho R #1

15. Filed 12-1, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 3, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 '29, 19.., to July 3 '29, 19..
that I last saw him alive on July 3, 19..,
and that death occurred, on the date stated above, at 12 noon m.
The CAUSE OF DEATH* was as follows:-
Drowning (accidental)

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? —
What test confirmed diagnosis? .....
(Signed) W. R. West, M. D.
7/7, 1929 (Address) Rigby, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho	7/6/29
20. Undertaker	Address
[illegible] Eckersell	Rigby.

RECEIVED DEC 19 1929

Anderson

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 98

DO NOT WRITE IN THIS SPACE
State File No. 68789

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME George Harper.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of (~~WIFE of~~) Zenobia Jane Harper.

6. DATE OF BIRTH (month, day and year) Jan. 24, 1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	61	7	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9. BIRTHPLACE (city or town) (State or country) Utah.

PARENTS

10. NAME OF FATHER Chas. Alfred Harper.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Harriet Taylor.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Zenobia J. Harper
(Address) Rigby, Idaho. R. #1

15. Filed 11-1, 1929 W. H. Larsen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 15th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from on Sept 10, 1920, to ✓, 19 ✓
that I last saw her alive on Sept 15, 1929
and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:
Sudden Cardiac Failure
Probably - Coronary Thrombosis

(duration) yrs. mos. one ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) H. A. Anderson, M. D.
Sept 18, 1929 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho.	9/18/29

20. Undertaker A. B. Carlson Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 19 1929

PLACE OF DEATH

County of Jefferson

City of Menan, Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 98

Primary Registration District No. 2176

(No. 161a)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68790

Local Registrar's No.

2. FULL NAME Baby Cherry.

(a) Residence. No. Menan, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ? Male

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 18, 1929

7. AGE Years | Months | Days | If LESS than 1 day, 1 1/2 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Baby

(c) Name of employer

9. BIRTHPLACE (city or town) Menan, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Levant Cherry

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Blanche Merrill

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Minn

14. Informant Levant Cherry
(Address) Menan Idaho

15. Filed 11-1, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 18 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/18, 1929, to 9/18, 1929, that I last saw h[illegible] alive on 9/18, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature birth
about 6½ mo. gestation

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Earl D. Jones, M. D.

9/19, 1929 (Address) Roberts Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal [illegible] | Date of Burial 9-18 1929

20. Undertaker [illegible] Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REC'D DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68791

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 3176

Local Registrar's No. 164

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Southwick

(a) Residence. No. Clark St. Idaho.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Louisa Marria Shupe

6. DATE OF BIRTH (month, day and year): June 14 1849

7. AGE: Years 80 | Months 1 | Days 5 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: Joseph Southwick
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Mary Walters
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Louisa Phillips
(Address) Clark. Idaho

15. Filed 11-1, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1929, to July 19, 1929
that I last saw h[illegible] alive on July 19, 1929
and that death occurred, on the date stated above, at 4:30 m.
The CAUSE OF DEATH* was as follows:
Old age
Debility
Arteria-Sclerosis 2 yrs.
(duration)
CONTRIBUTORY (Secondary) Age
(duration) 80 yrs.

18. Where was disease contracted if not at place of death? ~
Did an operation precede death? NO Date of ~
Was there an autopsy? NO
What test confirmed diagnosis? None
(Signed) H. T. Anderson M. D.
July 19, 1929 (Address) Rigby, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ogden Utah. | Date of Burial: 7/21 1929

20. Undertaker: A B Edwards | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 19 1929

PLACE OF DEATH

County of Jefferson

City of Lewisville.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 78

Registration District No. 78

Primary Registration District No. 2176

DO NOT WRITE IN THIS SPACE

State File No. 68792

Local Registrar's No. 164

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Helen Adelia Ellsworth.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Widowed.

5a. If married, widowed, or divorced ~~XXXXXXXX~~ (or) WIFE of Brigham Henry Ellsworth.

6. DATE OF BIRTH (month, day and year) Sept. 10, 1848

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	10	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Wyoming.
(State or country)

PARENTS

10. NAME OF FATHER Henry Elliot Gibson.

11. BIRTHPLACE OF FATHER (city or town) England.
(State or Country)

12. MAIDEN NAME OF MOTHER Eliza Gibbs.

13. BIRTHPLACE OF MOTHER (city or town) Scotland.
(State or Country)

14. Informant Chas E Ellsworth

(Address) Lewisville, Idaho

15. Filed 11-1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 21 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ by telephone to on July 20 19 29

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Senility

Arterio Sclerosis

Cardiac Fibrosis & Decompensation

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Age

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. A. Anderson, M. D.

....., 19..... (Address) Rigby

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewisville, Idaho.	7/23/29 19

20. Undertaker [signature] Address Rigby

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68793

Registration District No. 96
Primary Registration District No. 2176
Local Registrar's No. 48

PLACE OF DEATH

County of Jefferson
City of Rigby
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alfred K. Dabell.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of (or WIFE of) Pauline Dabell.

6. DATE OF BIRTH (month, day and year) May 14th 1850

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	1	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England.

PARENTS

10. NAME OF FATHER Alonzo Dabell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Harreitt Lambert
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant A. W. Dabell
(Address) Rigby, Idaho.

15. Filed 11-1, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30th, 1929, to [illegible], 19[illegible]
that I last saw him alive on June 30 1929
and that death occurred, on the date stated above, at 6 A m.
The CAUSE OF DEATH* was as follows:—
Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) O. A. Anderson, M. D.
July 16, 1929 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grant, Idaho.	7/3/29 19
20. Undertaker	Address
A B Eckersell	Rigby

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68794

PLACE OF DEATH
County of Jefferson
City of Menan.

CERTIFICATE OF DEATH
Registration District No. 98
Primary Registration District No. 2116
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

2. FULL NAME Arnold Elton Hunting.

(a) Residence. No. 112 St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Babe.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Babe

6 DATE OF BIRTH (month, day and year) August 18, 1927

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	0	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Babe
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Menan, Idaho.

PARENTS
10 NAME OF FATHER George Edmund Hunting.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Menan, Idaho.
12 MAIDEN NAME OF MOTHER Rhoda Harmon.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah.

14 Informant George Edmund Hunting
(Address) Menan, Idaho.

15 Filed 11-1, 19 29 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8 (Month) 20 (Day) 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 8/18, 19 27, to 8/20, 19 27, that I last saw him alive on 8/20, 19 27, and that death occurred, on the date stated above, at 4:45 m.

The CAUSE OF DEATH* was as follows:
Acute Infectious Intoxication
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) D.A.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinic Symptoms
(Signed) Earl D. Innes, M. D.
8/21, 19 29 (Address) Roberts Idy

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Annis, Idaho	8/22/29 19

20. Undertaker [signature] Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68795

PLACE OF DEATH
County of Jefferson
City of Roberts

Registration District No. 98
Primary Registration District No. 2176
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1
16b

2. FULL NAME Winnfred (Strange) Pope.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. M.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced ~~XXXXXXXX~~ (or) WIFE of Chas. Erenest Pope.

6. DATE OF BIRTH (month, day and year) June 19, 1898

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
31	1	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: John W. Strange.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah.
12. MAIDEN NAME OF MOTHER: Annie Overson.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Mrs Annie Strange
(Address) 1525 Edson St. Salt Lake City, Utah

15. Filed 11-1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 8th (Month) 1929 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1929, to Aug 8, 1929
that I last saw her alive on Aug 8, 1929
and that death occurred, on the date stated above, at 3.30 p m.
The CAUSE OF DEATH* was as follows:
Phenol Poisoning
Self administered
Suicidal intent
..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Probable Transient Dementia
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Earl D Jones M. D.
8/9, 1929 (Address) Roberts Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby Ida. Date of Burial: 8/11 1929

20. Undertaker: A B Eckersell Address: Rigby

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68796

PLACE OF DEATH

County of Jefferson

City of Rigby

CERTIFICATE OF DEATH 98

Registration District No. 98

Primary Registration District No. 2176

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

182

2. FULL NAME Merle Joice Montgomery.

(a) Residence. No. Ririe, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F. M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child.

6 DATE OF BIRTH (month, day and year) May 31st, 1923

7 AGE: Years 5 | Months 11 | Days 30 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Idaho.

PARENTS

10 NAME OF FATHER: David C. Montgomery

11 BIRTHPLACE OF FATHER (city or town) (State or country): Oregon.

12 MAIDEN NAME OF MOTHER: Margaret E. Adams.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Idaho.

14 Informant: [illegible]

(Address) Ririe, Idaho.

15 Filed 11-1, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 30th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
Body recovered from Snake River
bea August 11th-1929
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Graf Taylor Coroner M. D.

8/12/29, 19 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Shelton, Idaho.

Date of Burial: 8/12/29 19

20. Undertaker: [illegible]

Address: Rigby

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 19 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jefferson

City of Hamer

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98

Primary Registration District No. 2176

(No. ....., ... St.)

File No. 68797

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Maria Ericksen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: April (Month) 2 (Day) 1845 (Year)

7. AGE: 84 Yrs. 5 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Andrew Madsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Anna Madsen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leonard Ericksen

(Address) Hamer, Idaho

15. Filed 9-4 1929. C. H. Farren, Local Registrar

MEDICAL CERTIFICATE OF DEATH

74 B

16. DATE OF DEATH: September (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/2/ 1929, to 9/2/29 1929, that I last saw her alive on ~~9/2~~ 9/2 1929, and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

Emboli - Cerebral

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earl D. Jones M. D.

9/4 1929 (Address) Roberts Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt Pleasant, Utah

DATE OF BURIAL: Sept. 1929

20. UNDERTAKER: Jack A. Wood

ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 29

DO NOT WRITE IN THIS SPACE
State File No. 62708

PLACE OF DEATH
County of Jefferson
City of Menan.

Registration District No.
Primary Registration District No. 2176
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its *name* instead instead of street and number.)

16 c

2. FULL NAME William Leese.

(a) Residence. No. Roberts, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~XXXXXXX~~ Rose Leese

6 DATE OF BIRTH (month, day and year) Oct. 20. 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	0	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) England

PARENTS
10 NAME OF FATHER James Leese
11 BIRTHPLACE OF FATHER (city or town) (State or country) England.
12 MAIDEN NAME OF MOTHER Harriet (Unknown)
13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Rose Leese
(Address) Terreton, Idaho.

15 Filed 12-1, 1929 T. J. Larsen Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November (Month) 4th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,
that I last saw him alive on Nov-4- 1929,
and that death occurred, on the date stated above, at 6 P.M. m.

The CAUSE OF DEATH* was as follows:
Fractured Skull from Auto Accident

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Sudden (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Eva Taylor Coroner M.D.
11/5, 1929 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho.	11/7 1929
20. Undertaker O B Eckersell	Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68799

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Jefferson — Registration District No. 98
City of Rigby — Primary Registration District No. 2176
(No. ....)
Local Registrar's No. ....

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME William Henry Chapman.

(a) Residence. No. .... St. ....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred .... yrs. .... mos. .... ds. How long in U. S., if of foreign birth? .... yrs. .... mos. .... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
~~WIFE~~ Emma Ellen Ward.

6 DATE OF BIRTH (month, day and year) April 1 1850

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
79	6	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Wm. Chapman.
11 BIRTHPLACE OF FATHER (city or town) (State or country) England.
12 MAIDEN NAME OF MOTHER Rachial Watson.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Geo L Chapman
(Address) Rigby, Idaho.

15 Filed 12-1, 1929 C O Larson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October (Month) 24th (Day) 1929 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1929, to Oct. 23, 1929, that I last saw him alive on Oct. 23, 1929, and that death occurred, on the date stated above, at 7.30P m.

The CAUSE OF DEATH* was as follows:
Cystitis & Pyelitis.
.... (duration) 10 yrs. .... mos. .... ds.
CONTRIBUTORY (Secondary) Senility
.... (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of ....
Was there an autopsy? No
What test confirmed diagnosis? ....

(Signed) W. R. West, M. D.
Oct. 26, 1929 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Preston, Idaho.	10/27/29

20. Undertaker — Address
C B Eckersell

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68800

PLACE OF DEATH

County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Eliza J. Brown.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. M.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced ~~[illegible]~~ (or) WIFE of Joseph D. Brown.

6. DATE OF BIRTH (month, day and year) Feb. 10th1862

7. AGE: Years 67, Months 8, Days 7. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England.

PARENTS
10. NAME OF FATHER John Taylor.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Ann Harris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Jos. D. Brown
(Address) Rigby, Idaho.

15. Filed 12-1, 1929 C. H. Yavin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 17th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16, 1929, to Oct 17, 1929
that I last saw her alive on Oct 17, 1929
and that death occurred, on the date stated above, at 6:30 p.m.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Rigby, M. D.
10-25, 1929 (Address) C. H. Yavin

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby, Idaho
Date of Burial: 10/20/29 19

20. Undertaker: A. B. Eckersell
Address: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 78

DO NOT WRITE IN THIS SPACE
State File No. 68801

PLACE OF DEATH

County of Jefferson
City of Rigby
Registration District No. 78
Primary Registration District No. 2176
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

94 0

2. FULL NAME Edith Francis Hoggan

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND OF~~
(or) WIFE of George T. Hoggan.

6 DATE OF BIRTH (month, day and year) Nov. 11, 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	11	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Ralph Harris.
11 BIRTHPLACE OF FATHER (city or town) (State or country) England
12 MAIDEN NAME OF MOTHER Mary Edmunds.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant W W Hoggan
(Address) Arco, Idaho.

15 Filed 12-1, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November (Month) 6th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1929, to Nov. 6, 1929, that I last saw her alive on Nov. 6, 1929, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis & Valvular heart disease

(duration) 5 days mos. ds.

CONTRIBUTORY (Secondary) Chr. Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Test, M. D.

Nov. 15, 1929 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Rigby, Idaho	11/9/29

20. Undertaker [signature] Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 98

DO NOT WRITE IN THIS SPACE
State File No. 68802

PLACE OF DEATH
County of Jefferson
City of Ririe

Registration District No.
Primary Registration District No. 2176
(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

179

2. **FULL NAME** Christina Johnson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Married.

5a If married, widowed, or divorced
~~HUSBAND OF~~
(or) WIFE of Chas. A. Johnson.

6 DATE OF BIRTH (month, day and year) March 17 1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	8	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Utah.

PARENTS
10 NAME OF FATHER (Unknown) Adamson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland
12 MAIDEN NAME OF MOTHER Ann McCoslum.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Chas A Johnson
(Address) Ririe, Idaho.

15 Filed 12-1, 1929 C. H. Lavin
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
November (Month) 19, 1929 (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1929, to Nov 19, 1929, that I last saw h~~er~~ alive on Nov 19, 1929, and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Burns - sustained while cleaning clothes in gasoline which ignited from a nearby stove. Money damages. Ohio 30... to Fletcher
(duration) yrs. mos. ds.

CONTRIBUTORY Shock
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. K. Aldrich, M. D.
Nov 20, 1929 (Address) Ririe Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Rigby, Idaho.	

20. Undertaker	Address
C. E. Edwards	Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 10 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68802

W.R. Abbott M.D.
Ririe, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of;

Christina Johnson who died at Ririe, Idaho on Nov. 19, 1929
Cause of death given as "Burns.Shock."

Information DESIRED in order to complete certificate:

WILL YOU PLEASE STATE WHETHER OR NOT A BURNING BUILDING WAS INVOLVED? THESE ARE CLASSIFIED SEPARATELY.

PLEASE ANSWER BELOW:

The burns were sustained while cleaning clothes in gasoline which became ignited by a nearby stove. Only minor damage was done to the kitchen in which the cleaning was being done

H. R. Abbott M. D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 19 1929

PLACE OF DEATH

County of Jefferson

City of Rigby

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 98

Primary Registration District No. 2176

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68803

Local Registrar's No. .....

161a

2. FULL NAME Leon Taylor Brown.

(a) Residence. No. Rigby. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Baby

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days | If LESS than 1 day, 7 hrs. or 15 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Baby.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Rigby

PARENTS

10. NAME OF FATHER: George Brown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Virginia Brady

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant (Address): George Brown.

15. Filed 12-1, 1929 C. H. Irvin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 26 (Month) 1929 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from On Oct 26, 1929, to ✓, 19✓

that I last saw him alive on Dec 26 1929

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. A. Anderson, M. D.

, 19 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby

Date of Burial: 10/27 1929

20. Undertaker: A B Eckersell

Address: Rigby

FORM V. S. No. 5-A—25 M. 1-19. RECEIVED JAN 16 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jerome

City of Eden

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23

Primary Registration District No. 2017

(No. ..... , ... St.)

File No. 68804

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Eugene Webb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 13 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 33 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Arthur R Webb

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Georgiana Johansen

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S Hopper

(Address) Hazelton

15. Filed Jan 1 1930 S Hopper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15 (Day) 1929 (Year) 100a

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1929, to Dec 15 1929 that I last saw him alive on Dec 15 1929, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Scurvy and Broncho Pneumonia

Scurvy (Duration) ..... Yrs. 1½ mos. ..... ds.

Contributory (Secondary) .....

Pneumon (Duration) ..... yrs. ..... mos. 9 ds.

(Signed) Simeon Hopper M. D.

..... 19 ..... (Address) Hazelton

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: 12-16 1929

20. UNDERTAKER: none

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 13 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jerome

City of Jerome

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18

Primary Registration District No.

(No. , St.)

File No. 68806

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Dee Bartholomew

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1929 (Year)

7. AGE: X Yrs. 1 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. M. Bartholomew

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mondie Hollabough

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bert Hollabough

(Address) Jerome Idaho

15. Filed 11/14 1929 Chas F Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 14 (Day) 1929 (Year) 11a

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12 1929, to Nov. 14 1929, that I last saw him alive on Nov. 14 1929, and that death occurred on the date stated above, at 1 a. M.

The CAUSE OF DEATH* was as follows:

Anaphylaxis due to protein allergy Intestinal

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. F. Zeller M. D.

19 (Address) Jerome, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Idaho

DATE OF BURIAL: 11/14 1929

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 13 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 18

File No. 6880

County of Jerome

Primary Registration District No.

Registered No.

City of Jerome (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Carbuhn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Nov (Month) 16 (Day) 1929 (Year)

7. AGE: X Yrs. X Mos. X ds.

IF LESS than 1 day how many 1 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer): 0

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harry Carbuhn

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Kittie McKinzie

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Carbuhn

(Address) Jerome

15.

Filed 11/16 1929 Chas F Zeller. Local Registrar

Jme

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 16 (Month) (Day) 1929 (Year)

16A

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16 1929, to Nov. 16 1929, that I last saw h.im alive on Nov. 16 1929, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature twin infant undeveloped

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Zeller M. D.

11/16 1929 (Address) Jerome, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Idaho.

DATE OF BURIAL: 11/16 1929

20. UNDERTAKER

ADDRESS

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68808

PLACE OF DEATH

County of Jerome
City of Jerome
Registration District No. 15
Primary Registration District No.
Local Registrar's No. 161A
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Canbulan

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
X	X	X	X	12 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Jerome Idaho

PARENTS

10. NAME OF FATHER Harry Canbulan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Kettie McKenzie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Harry Canbulan
(Address) Jerome Idaho

15. Filed 11/17, 1929 Chas F Zeller Jr. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16, 1929, to Nov 17, 1929
that I last saw him alive on Nov 17, 1929
and that death occurred, on the date stated above, at m.
The ~~CAUSE~~ OF DEATH* was as follows:
Premature Twin Infant
Undeveloped
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. F. Zeller, M. D.
11/17/29, 19 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Jerome Idaho	11/17 1929
Undertaker —	Address —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 13 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Wendell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18

Primary Registration District No.

(No. , St.)

File No. 68809

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Caroline Ekund

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 24 (Day) 1849 (Year)

7. AGE: 33 Yrs. 10 Mos. 14 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Okla

10. NAME OF FATHER: T. D. Jones

11. BIRTHPLACE OF FATHER (State or Country): Louisiana

12. MAIDEN NAME OF MOTHER: Mary Nat Kuns

13. BIRTHPLACE OF MOTHER (State or Country): Mo. K.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr W. L. Ekund

(Address) Jerome Idaho

15. Filed 12/11 1929 Chas F Zeller. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 9 (Day) 1929 (Year) 10th

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19 1929, to Feb. 24 1929, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Zeller M. D.

12/11 1929 (Address) Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Idaho — DATE OF BURIAL: 12/11 1929

20. UNDERTAKER: D. L. Harrison — ADDRESS: Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. 6-25 M. 1-10 RECEIVED JAN 13 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jerome

City of Jerome

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18

Primary Registration District No.

(No. , St.)

File No. 68810

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma L Ward

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Oct (Month) 16 (Day) 1856 (Year)

7. AGE: 74 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: — Beal

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Mary Holland

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice Glasgow

(Address) Buhl

15. Filed 12/3 1929 Chas F Zeller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2 (Day) 1929 (Year) 122

17. I HEREBY CERTIFY, That I attended deceased from July 2 1929, to Dec. 2 1929 that I last saw her alive on Dec. 2 1929, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) Yrs. mos. ds.

Contributory (Secondary) Myocarditis Chronic

(Duration) yrs. mos. ds.

(Signed) C. F. Zeller M. D.

12/2 1929 (Address) Jerome, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Idaho

DATE OF BURIAL: 12/4 1929

20. UNDERTAKER: Da L Harrison

ADDRESS: Jerome Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 13 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 18

County of Jerome

Primary Registration District No.

File No. 68811

City of Jerome (No. ..... St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles A Fisher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Sept (Month) 7 (Day) 1869 (Year)

7. AGE: 60 Yrs. 1 Mos. ds. 00 — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: William W Fisher

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary M May

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Bertha Ruble
(Address): Winchester, Ind. RFD 1

15. Filed 12/8 1929 — Chas F Zeller Jr. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw h... alive on ..... 19...,
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Found dead in Hotel room.
Had bad heart.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J R Wiley Coroner M. D.
Dec 5, 1929 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jerome, Idaho	Dec. 5. 1929
20. UNDERTAKER	ADDRESS
D. A. L'Herisson	Jerome, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68812

PLACE OF DEATH
County of Kootenai
City of Athol

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 172

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188

2. FULL NAME Carl M. Ervin

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. (If married, widowed, or divorced) HUSBAND of (or) WIFE of Agnes M. Ervin

6. DATE OF BIRTH (month, day and year) July-27-1901

7. AGE: Years 28 | Months 3 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gravette Arkansas

PARENTS

10. NAME OF FATHER Walter Ervin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cossville Missouri
12. MAIDEN NAME OF MOTHER Sarah K —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Gravette Arkansas

14. Informant Jerrey Rickel
(Address) Athol Idaho

15. Filed 12/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 25. 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows: Accident, unloading logs from truck, a log struck him, knocked him down and crushed in whole right side of head and fracture of right thigh. At suggestion of County Coroner examined into the case and found above facts.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no, only examination.
What test confirmed diagnosis? .....
(Signed) Frank Wessy, M. D.
12/2, 1929. (Address) Rathdrum Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Athol Idaho
Date of Burial: 11-27 1929

20. Undertaker: Cassedy Funeral Home
Address: Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 1 1930

PLACE OF DEATH

County of Kootenai

City of Near Post Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68813

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 189

188e

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Boyd

(a) Residence. No. East 1427 15th Street St. Spokane, Wn.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 6, 1911

7. AGE Years 18 Months 11 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work High School Student

(b) General nature of industry, business, or establishment in which employed (or employer) High School student

(c) Name of employer

9. BIRTHPLACE (city or town) Tacoma
(State or country) Washington

PARENTS

10. NAME OF FATHER J. A. Boyd

11. BIRTHPLACE OF FATHER (city or town) Penna
(State or Country)

12. MAIDEN NAME OF MOTHER Della Garland

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant A Boyd
(Address) Spokane Wn

15. Filed 12/29, 1929. H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——, 19..., to ——, 19...

that I last saw h..... alive on ——, 19...

and that death occurred, on the date stated above, at 12:45 A m.

The CAUSE OF DEATH* was as follows: auto accident, Pinned under car, Strangled & suffocated, Head injuries,

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) R B Doony Coroner M. D.

12/17, 1929 (Address) Round Blue Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane Wn

Date of Burial 1929

20. Undertaker Hoyen & Teagen

Address Spokane Wn

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68814

PLACE OF DEATH

County of Kootenai

City of Near Post Falls

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 190

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188e

2. FULL NAME Richard Nolan

(a) Residence. No. 418 East Pacific Ave. St. Spokane, Wn
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 17 1907

7. AGE: 21 Years | Months: 11 | Days: 28 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Spokane, Wn.

PARENTS

10. NAME OF FATHER: Joseph Nolan

11. BIRTHPLACE OF FATHER (city or town) (State or Country): New Jersey

12. MAIDEN NAME OF MOTHER: Laura Sims

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Texas

14. Informant: Mr. Joseph H. Nolan
(Address) E418 Pacific

15. Filed 12/29, 1929. H. J. Sturges, Registrar

MEDICAL CERTIFICATE OF DEATH

16.* DATE OF DEATH: Dec (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——, 19..., to ——, 19...

that I last saw h..... alive on ——, 19...

and that death occurred, on the date stated above, at 12:45 A.m.

The CAUSE OF DEATH* was as follows:
auto accident, fined under car, strangled & suffocated,

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

12/17, 1929 (Address) Bound Oleum, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane Wn. | Date of Burial: 12-18 1929

20. Undertaker: Smith & Co | Address: Spokane Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 13 1930

PLACE OF DEATH
County of Kootenai
City of Coeur d Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30
Primary Registration District No. 1650

DO NOT WRITE IN THIS SPACE
State File No. 68815

Local Registrar's No. 191

(No. 44B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George J Williams

(a) Residence. No. 713 N Seventh St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Emma C Williams

6. DATE OF BIRTH (month, day and year) Nov 11 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
	70	1	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work architect
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Henry Co. Ill.

PARENTS

10. NAME OF FATHER Robt Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. J.
12. MAIDEN NAME OF MOTHER Lucitia Lester
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. J.

14. Informant Mrs Emma Williams
(Address) Coeur d'alene Idaho.

15. Filed 12/29/29, 1929 N. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1929, to Dec 22 1929
that I last saw him alive on Dec. 22 1929
and that death occurred, on the date stated above, at 5 45 P m.
The CAUSE OF DEATH* was as follows:
Probable myocarditis.
Sudden death after exertion.
(duration) Not known ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J C Drury M. D.
12/22, 1929 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	12/24 1929

20. Undertaker P B Mooney Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68816

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1650

Local Registrar's No. 192

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emily L. Tolman

(a) Residence. No. Twin Lakes St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. W. Tolman

6. DATE OF BIRTH (month, day and year) June 16 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	6	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retoucher of photograph negatives
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Marion
(State or country) Ohio

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant E. L. Tolman
(Address) Rathdrum Idaho

15. Filed 12/21, 1929. N. L. Thurgee Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 29, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929, to Dec. 29, 1929
that I last saw h-r alive on Dec 24, 1929
and that death occurred, on the date stated above, at 1.00 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
a cont 2
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Subacute Cholecystitis
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of -
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Frank Harris, M. D.
12/31, 1929. (Address) Rathdrum Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Grove Cemetery-Rathdrum	12/31 1929
20. Undertaker Casady Funeral Home	Address Rathdrum

REC... JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68817

PLACE OF DEATH

County of Shoshone
City of Rathdrum

Registration District No. 20
Primary Registration District No. 1650

Local Registrar's No. 193

(No. 201)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minnie O. Goodrich

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Fred Goodrich

6. DATE OF BIRTH (month, day and year): April 21 - 1851

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
78	7	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Olean New York

PARENTS

10. NAME OF FATHER: Linden Stevens
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dont Know

14. Informant: Levi Goodrich
(Address) Post Falls Idaho

15. Filed 12/29 1929 A. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 11th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1929, to Dec 11, 1929
that I last saw her alive on Dec 11, 1929
and that death occurred, on the date stated above, at 1.00 P.M.

The CAUSE OF DEATH* was as follows:
Fracture Left hip
Fell down stairs in church
(duration) yrs. 1 mos. 1 ds.
CONTRIBUTORY (Secondary) Chronic cystitis - old age
(duration) 2 or 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X Ray.

(Signed) Frank Watson, M. D.
12/12, 1929 (Address) P. Rathdrum Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Grove Cemetery	12-13 1929

20. Undertaker: Cassady Funeral Home — Address: Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 5 - 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68817

Frank Wenz
Rathdrum

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:
Minnie O. Goodrich who died at Rathdrum, Idaho on Dec. 11, 1929
Cause of death given as "Fracture Left Hip. Chronic cystitis. Old Age"

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Gentlemen:
Minnie Goodrich attended services at M. E. Church, fell down the flight of steps, about 6 - and fractured the hip - here in Rathdrum, Idaho.
Respectfully, Frank Wenz

Rathdrum, Ida. 4/3.30

NOV 14 1977

JUL 17 1961

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68818

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 194

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Samuel B. McElwayne

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine McDuffie McElwayne

6. DATE OF BIRTH (month, day and year) May 24 1877

7. AGE	Years	Months	Days	If LESS than 1 day,
	52	7	1	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Manager Continental Oil
(b) General nature of industry, business, or establishment in which employed (or employer) Plant at Rathdrum
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ~~State~~ Glen Locher Scotland

PARENTS

10. NAME OF FATHER Samuel McElwayne
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Margaret Monaghan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Beatrice Adams
(Address) Klamath Falls Oregon

15. Filed 12/29, 1929 H. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 25. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Decbr. 25, 1929, to Decbr. 25, 1929
that I last saw h— alive on Decbr. 25, 1929
and that death occurred, on the date stated above, at 6.20 A m
The CAUSE OF DEATH* was as follows: Acute Angina - Pectoris

15 minutes (duration) yrs. mos. ds

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Frank Henry, M. D
12/26, 1929 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery - Coeur d'Alene	12/29 192
20. Undertaker	Address
Cassedy Funeral Home	Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68819

PLACE OF DEATH
County of Bonner
City of Granite

Registration District No. 30
Primary Registration District No. 1058

Local Registrar's No. 195

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Laura Clark

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of A. J. Clark

6. DATE OF BIRTH (month, day and year) 1861-7-2

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	5	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Roseburg Ore

PARENTS

10. NAME OF FATHER Peter Baar
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Margaret Olmstead
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont know

14. Informant A. J. Clark
(Address) Granite Idaho

15. Filed 12/29, 1929 A. L. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 23, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1., 1927, to December 23, 1929
that I last saw h~~er~~ alive on Nov. 30., 1929
and that death occurred, on the date stated above, at 8-00 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
about 3 yrs.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Interstitial Nephritis
(duration) 1 yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Frank Hess, M. D.
12/24, 1929 (Address) Pathdrum Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Athol	12/25 1929
20. Undertaker	Address
Carey Funeral Home	Pathdrum

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 13 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 30
County of Kootenai — Primary Registration District No. 1030.
City of Hooley Ida. — (No. ..... St.)
File No. 68820
Registered No. 163
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Baptist Valles.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: Spokane. Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Sep. 10 1929 (Month) (Day) (Year)

7. AGE: Yrs. 1 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Hooley. Idaho.

10. NAME OF FATHER Jane Valles.

11. BIRTHPLACE OF FATHER (State or Country) Hooley. Idaho.

12. MAIDEN NAME OF MOTHER ~~Lolo~~ ~~Coot~~ Felicita Lodd Pine.

13. BIRTHPLACE OF MOTHER (State or Country) Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Rose Valles
(Address) Hooley. Ida.

15. Filed Nov 29 1929 N. J. Sturges Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 18th 1929. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 8 A.M. 1929, to Oct 18 11 A.M. 1929
that I last saw h[illegible] alive on Oct 18 8 A.M. 1929,
and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:
Congestion of Lungs.
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) T.B.
(Duration) ..... yrs. ..... mos. 3 ds.
(Signed) J. J. Harrington M. D.
19..... (Address) Hooley. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hooley Idaho — DATE OF BURIAL: Oct 19th 1929

20. UNDERTAKER: H. S. Jaeger. Plummer Ida. — ADDRESS: H. S. Jaeger. Plummer Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68821

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. Reed Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 169

2. FULL NAME Thomas Davidson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years about 49 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dont Know

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Dont Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Mrs Scofield.
(Address) Coeur d'Alene

15. Filed 12/29, 1929. H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1929, to Dec 5, 1929
that I last saw him alive on Dec 5, 1929
and that death occurred, on the date stated above, at 1:30 P m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J C Dunn, M. D.
Dec 7, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal Elk Wash | Date of Burial 12-8 1929

20. Undertaker Cassedy Funeral Home | Address C D Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68822

Registration District No. 30

Primary Registration District No. 1057

Local Registrar's No. 191

PLACE OF DEATH

County of Kootenai

City of Coeur d Alene

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth H Crawford

HH

(a) Residence. No. 807 A St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chas A Crawford

6. DATE OF BIRTH (month, day and year) Dec 17 - 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	76	11	21	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Phila. Penn.

PARENTS

10. NAME OF FATHER Thomas Busby

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Jane Harper

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant C A Crawford

(Address) Coeur d Alene Idaho

15. Filed 12/29, 1929 W. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 2 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1929, to Dec 2, 1929, that I last saw her alive on Dec 1, 1929, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver -

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of gall bladder

(duration) Not known yrs. mos. ds.

18. Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of 1927

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) J D Mann, M. D.

Dec. 3, 1929 (Address) Coeur d Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	Dec 4 1929

20. Undertaker P. D. Mooney Address Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68823

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 171

(No. Coeur d'Alene Homes)

(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME C. Milton Shelby

(a) Residence. No. C.d'A Homes St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Oct 1 1861

7. AGE: Years 68 Months 2 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Decorah Iowa

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Coeur d'Alene Homes

(Address): Coeur d'Alene Idaho.

15. Filed 12/29, 1929 H. J. Sturger Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1929, to Dec. 2, 1929 that I last saw him alive on Dec. 2, 1929 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Dwyer, M. D.

Dec. 2, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery

Date of Burial: 12/5 1929

20. Undertaker: R. B. Boney

Address: Coeur d'Alene

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68824

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 173

PLACE OF DEATH
County of Kootenai
City of Rathdrum
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1016

2. FULL NAME Beverly Jean Washburn

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 16 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 12 - 1928

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	4	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rathdrum Idaho

PARENTS

10. NAME OF FATHER Noah Washburn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Cora Flemming
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Mrs J. Washburn
(Address) Rathdrum Idaho

15. Filed 12/29, 1929. N. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 7. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1929, to Nov. 7. 1929
that I last saw her alive on Nov. 7, 1929
and that death occurred, on the date stated above, at 6.30. a.m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia (Acute)

(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Scarlet fever
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) Frank Henry, M. D.
11/7, 1929 (Address) Rathdrum Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Grove Cemetery Rathdrum	11/8 1929
20. Undertaker	Address
Sacred Funeral Home	Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68825

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 174

2. FULL NAME James D Ferguson. 48 B
(a) Residence No. County Hospital St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) April 9th 1846

7. AGE 83 Years | Months 6 | Days 26 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not known

PARENTS
10. NAME OF FATHER " "
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Mrs. Helen Brown.
(Address) Matron Kootenai County Hospital

15. Filed 12/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 5 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Nov. 5, 1929, that I last saw him alive on Nov. 4, 1929, and that death occurred, on the date stated above, at 9:00 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
about 2 (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic rheumatism and old age about 3 (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Frank Wess, M. D.
11/7, 1929, (Address) Rathdrum, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forrest Cemetery | Date of Burial 11-7 1929

20. Undertaker Cassedy Funeral Home | Address Rathdrum

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68826

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No.
Primary Registration District No.
Local Registrar's No. 175
(No. 101a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hattie E Pride

(a) Residence. No. 11th + Garden St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of J. M. Pride

6. DATE OF BIRTH (month, day and year) 1873 - 11 - 13

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	0	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Alton. Ill.

PARENTS

10. NAME OF FATHER Dont-Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Dont-Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant J. M. Pride
(Address) 11th and Garden

15. Filed 12/29, 1929 N. L. Stevens Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1929, to Dec 11, 1929
that I last saw h alive on Dec 11, 1929
and that death occurred, on the date stated above, at 12 10 P. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? -

(Signed) J. C. Brown, M. D.
12/12/, 1929 (Address) Over a Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Alton. Ill.	12- 1929
20. Undertaker Corsedy Funeral Home	Address Coeur d'Alene Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68827

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 176
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Andreas J. Higgens

(a) Residence. No. 15th & Indiana or 404 Indiana St. qo
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Amelia Higgens

6. DATE OF BIRTH (month, day and year) 1876-1-22

7. AGE	Years	Months	Days	If LESS than 1 day,
	53	10	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumber Worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER John Higgens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Inga Borg
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Curtis D. Higgens
(Address)

15. Filed 12/29, 1929 H. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1927, to Dec. 10, 1929
that I last saw h[illegible] alive on Dec. 10, 1929
and that death occurred, on the date stated above, at 130 P. m.
The CAUSE OF DEATH* was as follows:

Cardiac Decompensation
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Auricular fibrillation
Exophthalmic Goitre (duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Harold T. Anderson M. D.
Dec. 13, 1929 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CdAlene	12-12 1929

20. Undertaker	Address
Cassedy Funeral Home	CdAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 13 1930

DO NOT WRITE IN THIS SPACE
State File No. 68828

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 177

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Orvil Vernon Bradbury.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 21-1928

7. AGE — Years | Months: 10 | Days: 4 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rathdrum Ida.

PARENTS

10. NAME OF FATHER Elwin H. Bradbury.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spokane Wash.
12. MAIDEN NAME OF MOTHER Grace L. Howell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rathdrum Ida.

14. Informant Elwin H. Bradbury.
(Address) Rathdrum Ida.

15. Filed 12 31, 1929 M. L. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1929, to Oct. 25, 1929
that I last saw him alive on Oct. 25, 1929
and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:
Acute Bronchia-Pneumonia

(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Whooping Cough
(duration) yrs. 1 mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Frank Perry, M. D.
10/26, 1929, (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pine Grove Cemetery Rathdrum — Date of Burial: 10/27 1929
20. Undertaker: Caverly Funeral Home — Address: Rathdrum

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6882 9

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 178

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME Richard J. Sleep

(a) Residence. No. 311 Forest Drive St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Josephine Sleep

6. DATE OF BIRTH (month, day and year) Nov 21, 1873

7. AGE	Years	Months	Days	If LESS than 1 day,
	56	0	26	....hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Gas Station Operator
(b) General nature of industry, business, or establishment in which employed (or employer) Great Northern
(c) Name of employer Railway

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant William Sleep
(Address) Sand Point Idaho

15. Filed 12/29, 1929. N. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December - 17 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1929, to December, 1929
that I last saw him alive on Dec. 17, 1929
and that death occurred, on the date stated above, at 12 a. m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Harold J. Sturges, M. D.
Dec 18, 1929 (Address) Cda Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	12/19 1929
20. Undertaker R. B. Mooney	Address Cda Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68830

PLACE OF DEATH
County of Kootenai
City of Hayden Lake

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 179

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Katherine Lang
(a) Residence. No. Hayden Lake St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lang

6. DATE OF BIRTH (month, day and year) June 2 1861

7. AGE Years 68 Months 10 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10. NAME OF FATHER Gottlieb Riech
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Maggie Borner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant Jacob Lang
(Address) Hayden Lake Ida

15. Filed 12/12, 1929. H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 12. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15., 1929, to Dec. 12., 1929
that I last saw her alive on Dec. 10., 1929
and that death occurred, on the date stated above, at 8.00 a.m.
The CAUSE OF DEATH* was as follows:
Cancer Stomach

about 1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis
about 3 (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Frank Wenz, M. D.
12/12, 1929. (Address) Rathdrum Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Cleveland N. D. | Date of Burial 19

20. Undertaker R B Mooney | Address Cal A Ida

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6883

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 20
Primary Registration District No. 1950
(No.)
Local Registrar's No. 180

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ella Miller

(a) Residence. No. 961 7th St. 90
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Edward Miller

6. DATE OF BIRTH (month, day and year) 1867 - 8 - 4

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	4	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wis.

PARENTS

10. NAME OF FATHER Wolif Wonderly
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Ella Ruty
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Edna Miller
(Address) Coeur d'Alene Ida

15. Filed 12/29, 1929 W. J. Harger Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend deceased 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart disease

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E. H. Teed M. D.
12-26, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CdAlene	12-27 1929
20. Undertaker	Address
Cassedy Funeral Home	CdAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68832

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene.
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 181
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

463

2. FULL NAME Paul P. Anderson.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 3rd 1912.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	9	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur d'Alene, Ida.

PARENTS

10. NAME OF FATHER P. E. Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway.
12. MAIDEN NAME OF MOTHER Bertha Solam.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway.

14. Informant P. E. Anderson
(Address) .....

15. Filed 12/29, 1929 H. L. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1929, to Dec. 14, 1929
that I last saw h.im alive on Dec. 14 1929
and that death occurred, on the date stated above, at 1.00 P. m.
The CAUSE OF DEATH* was as follows:
Ch. Myocarditis
.....(duration) 4 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
.....(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) Harold J. Sturgeon, M. D.
Dec. 26, 1929 (Address) CDA, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CDalene	12-26 1929
20. Undertaker	Address
Cassedy Funeral Home	CDalene.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68833

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 182

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Russell

(a) Residence. No. 1916 Front St.
(Usual place of abode)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Millie Russell

6. DATE OF BIRTH (month, day and year) March 1. 1865

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	9	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) State Highways

(c) Name of employer Dept. of Ida

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER White Russell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown Mich

12. MAIDEN NAME OF MOTHER ....

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ....

14. Informant Mrs Millie Russell
(Address) Coeur d'Alene Idaho

15. Filed 12/29, 1929. W. F. Sturgis (Registrar)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at 11:15 m.

The CAUSE OF DEATH* was as follows:
Died suddenly without Medical attention
(Probly Apoplexy)
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ....
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ....
Was there an autopsy? no
What test confirmed diagnosis? ....

(Signed) P. B. Mooney Coroner, M. D.
12/27, 1929 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	12/29 1929
20. Undertaker P. B. Mooney	Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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RECEIVED JAN 13 1930

PLACE OF DEATH

County of Kootenai

City of

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

DO NOT WRITE IN THIS SPACE

State File No. 68834

Local Registrar's No. 183

(No. 68)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Stone

(a) Residence. No. Coeur d'Alene St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 69	—	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer & Timber

(b) General nature of industry, business, or establishment in which employed (or employer) Timber

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Coroners Office

(Address) Coeur d'Alene Ida.

15. Filed 12/29, 1929 H. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Found dead Dec 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Found dead in home
alcoholism & exposure
(Probably died 24 hrs before found)
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. D. Downey Coroner M. D.

12/23, 1929 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	12/27 1929

20. Undertaker R. D. Downey Address Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68835

PLACE OF DEATH
County of Kootenai
City of

Registration District No. 3e
Primary Registration District No. 1650
Local Registrar's No. 184

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Josephine B. Pettersen

(a) Residence. No. Near Ford. Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 19 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alex Pettersen (deceased)

6. DATE OF BIRTH (month, day and year) Feb 13 1871

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	10	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Living on farm
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Jens Thorsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Anna M Svensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant Alfred Pettersen
(Address) Coeur d'alene Ida R.D.

15. Filed 12/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1928, to Dec. 26, 1929
that I last saw her alive on Dec. 24, 1929
and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:
Cancer of liver

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Harold J. Sturges, M. D.
Dec 27, 1929 (Address) CDA Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mica Creek Cemetery	Dec 30 1929

20. Undertaker	Address
R. D. Mooney	Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68836

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 185

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

(No.) 162
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Curtis Justus Higgens Jr.

(a) Residence. No. 402 - [illegible] St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1929 - 12 - 25 -

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	1/2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Ida.

PARENTS

10. NAME OF FATHER Curtis J. Higgens
11. BIRTHPLACE OF FATHER (city or town) Big River Falls
(State or Country) Minn.
12. MAIDEN NAME OF MOTHER Inga Dahl
13. BIRTHPLACE OF MOTHER (city or town) Stanley
(State or Country) Wis.

14. Informant Curtis J. Higgens Sr.
(Address) 15th & Indiana ave.

15. Filed 12/29, 1929 N. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 27 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 25, 1929, to December 27, 1929
that I last saw him alive on December 26, 1929
and that death occurred, on the date stated above, at 5:00 A. m.
The CAUSE OF DEATH* was as follows:

Status Thymico-lymphaticus

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? /
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Horace T. Anderson M. D.
Dec. 27, 1929 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest-Cem. C'Alene	12-25 1929
20. Undertaker	Address
Cassedy Funeral Home	C'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

S. F. No. 825—1921. Approved as to Form by Dept. of Efficiency. 4832.

PLACE OF DEATH

Washington State Board of Health

Record No. 68837

County of Kootenai

BUREAU OF VITAL STATISTICS

Registered No. 186

City or Town of Coeur d'Alene

CERTIFICATE OF DEATH

Registration Dist. No. 30 No. 519 Coeur d'Alene street 74a

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME Caroline Parker

(a) Residence No. ..... St.; (Pochohantus Apts. Sec ane)

(Usual place of abode)

(b) If non-resident, give city or town, and state Spokane, Wash.

(c) How long in Registration Dist. ..... yrs. ..... mos. 1 ds.; how long in U. S. if of foreign birth ..... yrs. ..... mos. ..... ds.

Personal and Statistical Particulars

3. Sex: female
4. Color or Race: white
5. Single, Married, Widowed or Divorced (Write the word): widowed

5. (a) If married, widowed or divorced: Husband of Archie Parker or Wife of deceased.

6. Date of birth: May (Month) 4 (Day) 1864 (Year)

7. Age: 65 yrs. ..... mos. ..... ds. If less than one day hrs. ..... or min. .....

8. Occupation of deceased:
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. Birthplace (City or town) Stillwater
(State or country) Minn.

PARENTS

10. Name of Father: William Smidt
11. Birthplace of Father (City or town) (State or Country): Germany
12. Maiden name of Mother: Caroline Hole
13. Birthplace of Mother (City or town) (State or Country): Germany

14. Informant: Isabelle Parker
Address: 1803 W Second.

15. Filed 12/29, 1929 H. J. Sturges Registrar.

Medical Certificate of Death

16. Date of death: 12 (Month) 28 (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-28, 1929, to 12-28, 1929 that I last saw her alive on 12-28, 1929 and that death occurred on the date stated above, at 10 P m.
(State the disease causing death, or in deaths from violent causes, state: (1) Means and nature of injury; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL).
The CAUSE OF DEATH was as follows:

(Primary) Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted If not at the place of death? .....
(a) Did an operation precede death? No Date of .....
(b) Was there an autopsy? No
(c) What test confirmed diagnosis? .....

(Signed) E. H. Teed M. D.

12-28, 1929 Address Coeur d'Alene Ida

19. Place of Burial, Cremation or Removal: Stillwater Minn
Date of Burial: Jan. 2, 1929

20. Undertaker: Turnbull-Meager
Address: Spokane

I HEREBY CERTIFY, upon honor, That I have made the effort but was unable to secure answers to questions .....
(Insert numbers of unanswered questions)

..... (Signature of Undertaker)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

V. S. No. 1—100M—10-31-27.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68839

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 188

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

84B

2. FULL NAME Ann Canfield

(a) Residence. No. 205 Foster St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar Canfield

6. DATE OF BIRTH (month, day and year) 1845-5-6

7. AGE Years 84 Months 7 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Warren Co., Ohio

PARENTS
10. NAME OF FATHER John Mapples
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Jersey
12. MAIDEN NAME OF MOTHER Ellen Jefferys
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs Jasper Cooper
(Address) Coeur d'Alene, Ida

15. Filed 12/29, 1929 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1929, to Dec. 20, 1929
that I last saw her alive on December 20, 1929
and that death occurred, on the date stated above, at 1:30 P m.
The CAUSE OF DEATH* was as follows:
Myocardial Degeneration

..... (duration) two yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

..... (duration) ..... yrs. ..... mos. 1/2 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Harold T. Anderson, M. D.
Dec. 20, 1929 (Address) Coeur d'Alene, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene — Date of Burial 12-22 1929

20. Undertaker Cassedy Funeral Home — Address C D Alene

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68840

PLACE OF DEATH

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

(No. ....)

Local Registrar's No. 62

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

460

2. FULL NAME Maude Layton C'Dell

(a) Residence. No. N. Main St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Melvin F. C'Dell

6 DATE OF BIRTH (month, day and year) Jan. 9, 1895

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
34	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Palouse Wash.

PARENTS

10 NAME OF FATHER Geo. Layton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Oregon

12 MAIDEN NAME OF MOTHER Emma Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kansas

14 Informant Melvin F. C'Dell

(Address) Moscow, Ida.

15 Filed 12-29, 1929 W. H. Griffiths Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Dec. 29, 1929
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1929, to Dec. 29, 1929, that I last saw h.e alive on Dec. 29, 1929, and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Inflammatory Rheumatism

Endocarditis

.... (duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

.... (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. Caufield M.D.

12/30 19 29 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow	12/31/29 19
20. Undertaker	Address
E. R. Short	Moscow

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68841

PLACE OF DEATH

County of Latah
City of Moscow

CERTIFICATE OF DEATH

Registration District No. 61
Primary Registration District No. 1011
(No.) 162
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 61

2. FULL NAME William Green

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 12-17-1929

7 AGE Years Months Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Moscow Idaho

PARENTS
10 NAME OF FATHER Frank Green
11 BIRTHPLACE OF FATHER (city or town) (State or country) Dayton Wash.
12 MAIDEN NAME OF MOTHER Mabel Gage
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Genesee, Idaho

14 Informant Frank Green
(Address) Genesee, Idaho

15 Filed 12-18, 1929 W. H. Carithers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 18, 1929 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 12/18, 1929, to 12/19, 1929, that I last saw him alive on 12/19/, 1929, and that death occurred, on the date stated above, at 1 a.m. m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lues knot with in cord at birth.

(duration) yrs. 1 mo. mos. ds. inhaulerin.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C. Armstrong M. D.
12/19, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Genesee, Ida.
Date of Burial: 12/19/29 19

20. Undertaker: H. R. Short
Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68842

PLACE OF DEATH

County of Latah

City of Moscow

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

(No.) Local Registrar's No. 60

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Harold Baby Olson

(a) Residence. No. St. 206

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. 17, 1929

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Moscow Idaho

PARENTS

10 NAME OF FATHER Carl T. Olson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Moscow, Idaho

12 MAIDEN NAME OF MOTHER Martha J. Ostrom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tacoma Wash.

14 Informant Carl T. Olson
(Address) Moscow

15 Filed 12-17, 1929 W. T. Carothers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 17, 1929 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 11.45A m.

The CAUSE OF DEATH* was as follows:

Atelectasis
Premature birth - 7 mo.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature rupture of amniotic sac.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) C. Armstrong, M. D.

12/18, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Moscow

Date of Burial: 12/18/29

20. Undertaker: H. R. Short

Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. C8849

Local Registrar's No. 59

PLACE OF DEATH

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

(No. ....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

124

2. **FULL NAME** William Lawton Wells

(a) Residence. No. .... St. ....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. .... mos. .... ds. How long in U. S., if of foreign birth? .... yrs. .... mos. .... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct. 1, 1918

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
11	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Southwick Idaho

PARENTS

10 NAME OF FATHER Aaron J. Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Neb.

12 MAIDEN NAME OF MOTHER Bertha Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant A.J. Wells

(Address) Moscow, Ida.

15 Filed 12-6, 1929 W.T. Hawthorne Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 6, 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1929, to Dec. 6, 1929, that I last saw him alive on Dec 6, 1929, and that death occurred, on the date stated above, at 10:45 m.

The CAUSE OF DEATH* was as follows:

Acute Glomerular Nephritis

.... (duration) .... yrs. 6 mos. .... ds.

CONTRIBUTORY (Secondary) ....

.... (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Clinical only.

(Signed) C.A. Armstrong, M. D.

12/7, 1929 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Moscow, Ida.

Date of Burial: 12/8/29

20. Undertaker: H. P. Short

Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68841

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 6 S
Primary Registration District No. 2145

Local Registrar's No.

(No.) 44 B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Fletcher Fiscus.

(a) Residence. No. Potlatch Rt 2. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Jan 1st 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	11	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Bath Co Kentucky

PARENTS
10. NAME OF FATHER James. Fletcher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Shelby Co Ky.
12. MAIDEN NAME OF MOTHER Betty Stevens
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bath Co Ky

14. Informant Walter Fiscus.
(Address) Potlatch

15. Filed Dec. 24th, 1929 J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1929, to Dec. 24th, 1929, that I last saw her alive on Dec. 10th, 1929, and that death occurred, on the date stated above, at 830 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? ✓

(Signed) J. W. Thompson M. D.
Dec. 24th, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Truax Cem — Date of Burial: Dec 27 1929

20. Undertaker: E. H. Irwin — Address: Potlatch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68846

PLACE OF DEATH
County of Latah
City of Potlatch
Registration District No. 65
Primary Registration District No. 21 45
Local Registrar's No.
(No.) Western Hospital Association Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edna Nina Sanders

(a) Residence. No. 15-3 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo Sanders
6. DATE OF BIRTH (month, day and year): June 19 1905
7. AGE: Years 24 | Months 5 | Days 17 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10. NAME OF FATHER: William McGahan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Lela Lawson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Texas

14. Informant: Geo Sanders
(Address) Palouse Washington
15. Filed Dec 9 1929. J. Jr. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 6 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec. 6 1929, to Dec. 6 1929, that I last saw her alive on Dec 6, 1929, and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:

General peritonitis due to Pelvic abscess of unknown origen.
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Dec 6
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) F. F. C. Gibson M. D.
12/9/, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Palouse Wash — Date of Burial: Dec 9 1929
20. Undertaker: F. M. Lawson — Address: Palouse Wash.

RECEIVED JAN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68847

PLACE OF DEATH

County of Latah
City of Viola
Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

H3

2. FULL NAME Julianne Loretta Meeks

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years: 76 | Months: 0 | Days: 3 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Vermont

PARENTS

10. NAME OF FATHER: L. L. Gray
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Fannie Clark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: G. C. Meeks
(Address): Viola Ida

15. Filed Dec 10th, 1929 J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept., 1929, to Dec. 8th, 1929
that I last saw her alive on Dec. 1st, 1929
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:

Cancer of face.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? ✓

(Signed) J. W. Thompson, M. D.
Dec. 8th, 1929 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Viola Ida — Date of Burial: Dec 11 1929

20. Undertaker: J. M. Irwin — Address: Palouse Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68848

PLACE OF DEATH
County of Latah
City of Troy

Registration District No. 64
Primary Registration District No. 2144
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

167

2. FULL NAME David Steelsmith

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 26 - 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Troy Idaho

PARENTS

10. NAME OF FATHER B. F. Steelsmith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Hazel V Trout

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant B. F. Steelsmith
(Address) Troy Ida

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 29. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1929, to Dec 29, 1929, that I last saw him alive on Dec 28, 1929, and that death occurred, on the date stated above, at 1:15 a.m.

The CAUSE OF DEATH* was as follows:

Congenital heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas A. Dreyer M. D.

Dec 29, 1929. (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

TION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 6 1930

PLACE OF DEATH

County of Latah

City of Troy

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 64

Primary Registration District No. 2144

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68849

Local Registrar's No. .....

164

2. FULL NAME Enos Byers

(a) Residence. No. ..... St. .....

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Sarah A Byers

6. DATE OF BIRTH (month, day and year) June 13 - 1850

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	4	25	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Do

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Ezekiah Byers

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Delila Vance

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs Sarah A Byers

(Address) Troy Ida

15. Filed Dec 31, 1929 Ruby M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov-8, 1929, to Nov. 8, 1929, that I last saw h~~im~~ alive on Nov 8, 1929, and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was ~~as follows~~:

Senility.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas. A. Meyer, M.D.

Nov. 9, 1929 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Beaulah cem	Nov 10 1929
20. Undertaker	**Address**
John J. Pickard	Troy Ida

REC... JAN 6 1930

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah.

City of Genesee Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 62

Primary Registration District No. 2142

(No. ..... St.)

File No. 68850

Registered No. ...

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred. B. Perkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: Aug. (Month) 2 (Day) 1881 (Year)

7. AGE: 48. Yrs. ... Mos. 4 ds. 28

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Dealer Live Stock.

(b) General nature of industry, business or establishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Frank. Perkins

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Nevada Moore

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Perkins

(Address) Genesee

15. Filed 12-17- 1929 W. H. Ehrens Local Registrar

MEDICAL CERTIFICATE OF DEATH

89

16. DATE OF DEATH: Dec (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1929, to Dec 14 1929, that I last saw him alive on Dec 14 1929, and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Coronary Thrombosis

(Duration) ... yrs. 6 mos. ... ds.

(Signed) Walter A. Burg M. D.

Dec 17, 1929 (Address) Uniontown Wash.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Genesee Idaho.

DATE OF BURIAL: 12-19-29

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19

RECEIVED JAN 6 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 68851

Registered No. 3

1. PLACE OF DEATH

County of Latah County

City of Genesee Ida.

Registration District No. 62

Primary Registration District No. 2142

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Theodore Lundt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: January (Month) 11 (Day) 1858 (Year)

7. AGE: 72 Yrs. ..... Mos. 10 ds. 29

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: A. E. Lundt

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Sophia Eilertson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clifford Lundt

(Address) Genesee Idaho

15. Filed 12-10 1929

W. H. Elson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 9 (Day) 1929 (Year)

131

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1929, to Dec 9 1929, that I last saw him alive on Dec 9 1929, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Uremic Coma.

(Duration) — Yrs. — mos. 2 ds.

Contributory (Secondary) Paralysis Agitans

(Duration) 8 yrs. — mos. — ds.

(Signed) Walter A. Burg M. D.

Dec 10 1929 (Address) Uniontown Wn

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Maries Idaho

DATE OF BURIAL: 12-4 1929

20. UNDERTAKER: Brower - Hanna Co

ADDRESS: Lewiston Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 RECEIVED JAN 16 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Pottatch

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65

Primary Registration District No. 2145

(No. ..... St.)

File No. 68853

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ✓ (Month) ✓ (Day) 1867 (Year)

7. AGE: 62 Yrs. ✓ Mos. ✓ ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Woodman.

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway.

10. NAME OF FATHER: Not Known.

11. BIRTHPLACE OF FATHER (State or Country): Not Known.

12. MAIDEN NAME OF MOTHER: Not Known.

13. BIRTHPLACE OF MOTHER (State or Country): Not Known.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Pete Larson.

(Address) Spokane. Wash

15. Filed July 6th 1929 Dr. J. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

15-1

16. DATE OF DEATH: July (Month) 6th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4th 1929, to July 6th 1929, that I last saw him alive on July 6th 1929, and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Gas. Gangrene. following compound fracture of right femur

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) accident occurred in the woods during logging operations

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. C. Gibson. M. D.

July 6th 1929 (Address) Pottatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Elk. River. Idaho

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse

DATE OF BURIAL: 3 19 3

20. UNDERTAKER: E. Irwin.

ADDRESS: Palouse

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED APR 7 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68852

F.C. Gibson
Potlatch, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Charles Peterson who died at Potlatch, Idaho on July 6, 1929
Cause of death give as "Gas gangrene, following compound fracture of Rt. Femur."

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH? IF AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

This accident occurred during logging operations in the woods where he was employed —

D. F. C. Gibson

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68853

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

205 B

2. FULL NAME Anker E Amonson
(a) Residence. No. Lemhi St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 49 yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Emma Webber Amonson

6. DATE OF BIRTH (month, day and year)

7. AGE 49 Years | Months 11 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Salmon
(State or country) Lemhi Co

PARENTS

10. NAME OF FATHER Peter Amonson
11. BIRTHPLACE OF FATHER (city or town) Bergen
(State or Country) Norway
12. MAIDEN NAME OF MOTHER Christina Pederson
13. BIRTHPLACE OF MOTHER (city or town) Bergen
(State or Country) Norway

14. Informant E Amonson
(Address) Lemhi Idaho

15. Filed Jan 10, 1930 Clio E. Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 24th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 5-30 A m.
The CAUSE OF DEATH* was as follows: No Physician attended, Natural Causes, unknown No Inquest held.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) William C Doebler Coroner M.D.
12-24th, 1929 (Address) Salmon Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery | Date of Burial: 12-28" 1929

20. Undertaker: Wm C Doebler | Address: Salmon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 14 1930

PLACE OF DEATH

County of Lemhi

City of Gibbonsville

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 41

Primary Registration District No. 2116

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68854

Local Registrar's No.

105-B

2. FULL NAME Lena Royce

(a) Residence. No. Gibbonsville Idaho St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of A. V. Royce

6. DATE OF BIRTH (month, day and year) Oct 29th 1856

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	1	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Mc Kay

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant A. V. Royce

(Address) Gibbonsville

15. Filed Jan 10, 1930 Chas E Bill Reg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 22nd 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 1-P- m.

The CAUSE OF DEATH* was as follows: No Physician attended Natural Causes of Unknown. No Inquest held

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William C. Doebler Coroner

12-22", 1929 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gibbonsville, Ida	12-24th 1929.

20. Undertaker Wm C Doebler — Address Salmon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68855

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

90

2. FULL NAME Frank Means

(a) Residence. No. County Farm Salmon Ida. St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: about 70 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: County Patient
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): American

PARENTS

10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: Wm C Doebler
(Address) Salmon Idaho

15. Filed Jan 10, 1930 Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 21st 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan '29, 19..., to Dec 20, 1929
that I last saw him alive on Dec 20 19..
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:
Aortic regurgitation
about 21 years —
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Cholecystitis
several years (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
Jan 8, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery
Date of Burial: 12-22 1929

20. Undertaker: Wm C Doebler
Address: Salmon Ida

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68856

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

100a

2. FULL NAME John Gordon
(a) Residence. No. Salmon Hot Springs St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE about 73 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: County Patient
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): American

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Wm C Dachler
(Address) Salmon Idaho

15. Filed Jan 10, 1930 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1929, to Dec 1, 1929
that I last saw him alive on Dec 1, 1929
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia
About 4 weeks
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) General debility
Several years
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
Jan 5, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery
Date of Burial: 12-2" 1929

20. Undertaker: Wm C Dachler
Address: Salmon Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68857

PLACE OF DEATH

County of Lemhi
City of Salmon
Registration District No. 41
Primary Registration District No. 2116
(No. Rose Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 90

2. FULL NAME William Earl Cutney

(a) Residence. No. Lemhi St. Lemhi Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	8	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Torrington Wyo.

PARENTS

10. NAME OF FATHER Holland Lee Cutney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York City New York
12. MAIDEN NAME OF MOTHER Sarah Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Winterset Iowa

14. Informant Wm C. Doebler
(Address) Salmon Idaho

15. Filed Jan 10, 1930 Chas Billamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 22nd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12, 1929, to Nov 20, 1929
that I last saw him alive on Nov 20, 1929
and that death occurred, on the date stated above, at 3- A- m.
The CAUSE OF DEATH* was as follows:
Carcinoma Stomach
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Anemia
(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical symptoms
(Signed) W. C. Doebler, M. D.
Nov 23, 1929 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	11-23rd 1929
20. Undertaker	Address
Wm C. Doebler	Salmon Ida

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68858

PLACE OF DEATH
County of Lemhi
City of Salmon
Registration District No. 41
Primary Registration District No. 2116
(No. 910)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John L. Kirkpatrick

(a) Residence. No. Patterson Idaho St. Salmon General Hospital
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) October 4th 1863

7. AGE	Years	Months	Days	If LESS than 1 day,
	66	0	14	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Missouri
(State or country)

PARENTS

10. NAME OF FATHER William P. Kirkpatrick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Nannie Horn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant W. T. Kirkpatrick
(Address) Mgr. Idaho

15. Filed Jan 10, 1930 Chas E. Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 18th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929, to Oct 18, 1929
that I last saw h-- alive on Oct 18, 1929
and that death occurred, on the date stated above, at 2 A— m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Subintinately type
(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? May Idaho
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas E. Bellamy, M. D.
Jan 8, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
May Cemetery	October 20 1929
20. Undertaker	Address
Wm C Dockle	Salmon Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A-25M. 1 RECEIVED JAN 9 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68859

Local Registrar's No.

1. PLACE OF DEATH

County of Lewis

City of Kamiah

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Blackeagle Jr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: June (Month) 2 (Day) 1923 (Year)

7. AGE: 6 Yrs. 5 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Joseph Blackeagle

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ida Corbett

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Blackeagle

(Address)

15.

Filed ..... 19 .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st 1929, to Above 19 ....., that I last saw him alive on Nov. 18th 1929, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary S. B.

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Bryan M.D.

11/20 19 ..... (Address) Kamiah Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ..... 19 .....

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68860

PLACE OF DEATH
County of Lewis
City of Craigmont

Registration District No. 50
Primary Registration District No. 2129
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

90

2. FULL NAME William A. Bovey William August Bovey.,
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ota May Bovey

6. DATE OF BIRTH (month, day and year): Apr 5 1870

7. AGE: 59 Years, Months 8, Days 4. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer. retired
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Tama City, Tama Co Iowa

PARENTS
10. NAME OF FATHER: Noah R. Bovey
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pennsylvania
12. MAIDEN NAME OF MOTHER: Tamson Katt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Richmond Virginia

14. Informant: Cleo O. Bovey
(Address): Culdesac, Ida

15. Filed Jan. 6, 1930. Rec. Dunlap N.W.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec / 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to Dec 10, 1929
that I last saw him alive on Dec 10, 1929
and that death occurred, on the date stated above, at 8 45 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (duration) ..... yrs. ..... mos. 6 hours
CONTRIBUTORY (Secondary): Arterio-Sclerosis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) John F. Gist M. D.
12/10 1929 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: I.O.O.F. Cemetery Craigmont Ida
Date of Burial: Dec 14 1929

20. Undertaker: Coyle Clo Mrs
Address: Craigmont Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68864

PLACE OF DEATH
County of Lincoln
City of Shoshone

Registration District No. 16
Primary Registration District No. 1016
Local Registrar's No. 19
(No. Prosser Ranch 10 Miles West of Shoshone
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry A. Seiwert

74a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S.; if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Dora Seiwert

6. DATE OF BIRTH (month, day and year) Sept 4 1852

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
77	3	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Actor (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): New York City

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Lillian Prosser
(Address)

15. Filed Dec 4, 1929 J. L. Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended ~~deceased~~ from June, 19..., to June, 1929, that I last saw h..... alive on No — 19..., and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows: Cerebral apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Intestinal trouble, Not known
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? California
Did an operation precede death? No Date of No
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature] M. D.
..., 19... (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone Idaho
Date of Burial: Dec 21 1929

20. Undertaker: C. E. Hickok
Address: Shoshone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-10-12 RECEIVED JAN 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of [illegible]

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ....., ... St.)

File No. 68866

Registered No. 89

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Billie J. Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: December 18 1929 (Month) (Day) (Year)

7. AGE: 2 hrs ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Rexburg

10. NAME OF FATHER: Leon Taylor

11. BIRTHPLACE OF FATHER (State or Country): Willard, Utah

12. MAIDEN NAME OF MOTHER: Eliza Winager

13. BIRTHPLACE OF MOTHER (State or Country): Parker Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leon Taylor

(Address) Ashton Idaho

15. Filed 12/19 1929 J Rexburg Local Registrar

MEDICAL CERTIFICATE OF DEATH.

161a

16. DATE OF DEATH: December 18 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18 1929, to Dec 18 1929, that I last saw him alive on Dec 18 1929, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Patent foreman ovale

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H B Rigby M. D.

Dec 19 1929 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker

DATE OF BURIAL: 12-19 1929

20. UNDERTAKER: none

ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68867

PLACE OF DEATH

County of Madison. Registration District No. 100

City of Rexburg Primary Registration District No. 2178

(No. Dr. L. F. Rich Hosp.) Local Registrar's No. 88

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Victoria Elizabeth Campbell.

(a) Residence. No. 129 St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Married.

5a If married, widowed, or divorced
HUSBAND OF
(or) WIFE of Robt. L. Campbell.

6 DATE OF BIRTH (month, day and year) Feb. 19, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	62	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Thomas Barnard.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Elizabeth Stattar.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant H. L. Campbell

(Address) Rigby, Idaho. R #1

15 Filed 12/12, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. (Month) 10th (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1929, to Dec 10, 1929, that I last saw her alive on Dec 10, 1929, and that death occurred, on the date stated above, at 2.07 m.

The CAUSE OF DEATH* was as follows:

Uremia

chronic interstitial

(duration) r. 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Jefferson County Idaho

Did an operation precede death? No Date of

Was there an autopsy? No Symptoms & Laboratory findings

What test confirmed diagnosis?

(Signed) Louie A. Rich, M. D.

12-17-, 1929, (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Burton, Idaho.	12/13 1929
20. Undertaker	Address
A. B. Edwards	Rigby.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68868

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution give its name instead of street and number.)

Local Registrar's No. 87

2. FULL NAME Thomas Peter Statham

49

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ ~~(or) WIFE of~~

6. DATE OF BIRTH (month, day and year) Oct 30 - 1861

7. AGE Years 68 Months 1 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Ralph Rowberry
(Address) Rexburg Idaho.

15. Filed 1/3, 1930 J Ryoung Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-24, 1929, to 12-10, 1929
that I last saw him alive on 12-10, 1929
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Prostate

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) A. Rutherland, M. D.
12-12, 1929 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burton Idaho. Date of Burial Dec 12 1929

20. Undertaker Vern J. Keller Address Rexburg Ida.

FORM V. S. No. 5-25 M. 1-19. JAN 1 8 1930 **CERTIFICATE OF DEATH**

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68869

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce

City of Lapwai Idaho.

(No. ..... St.)

Registration District No. 128

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wishwa no 1

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	Indian 4/4	Widowed

6. DATE OF BIRTH

..... (Month) ..... (Day) 1844 (Year)

7. AGE

85 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF Father not known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Maxwell

(Address) Lapwai Idaho.

15.

Filed Oct 1929 Jorge Gaspard
Local Registrar

MEDICAL CERTIFICATE OF DEATH -0

16. DATE OF DEATH

Oct (Month) 10 (Day) 29 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,

that I last saw h..... alive on ..... 19...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Died without medical attendance

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaspard M. D.

Oct 1929 (Address) Kooskia Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lapwai Idaho.

DATE OF BURIAL 10-11 1929

20. UNDERTAKER Family

ADDRESS Lapwai Idaho.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

JAN 16 1930

State File No. 6887C

Registration District No. 128

Primary Registration District No.

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce

City of Webb Idaho.

(No. Culdesac & Vicinity St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian 3/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: July (Month) 30 (Day) 1929 (Year)

7. AGE: Yrs. 2 Mos. 10 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Frank Johnson

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Pauline Hill

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Johnson
(Address) Webb Idaho.

15. Filed Oct 1929 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 9 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 - 1929 to Oct 9 - 1929 that I last saw him alive on Oct 7 - 1929 and that death occurred on the date stated above, at 11:50 P.M.

The CAUSE OF DEATH* was as follows:
Gastro-Enteritis and Hemaphilia

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George Gaignard M. D.
10/9/1929 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Webb Idaho. Stickford Mission — DATE OF BURIAL: 10-10-1929

20. UNDERTAKER: Family — ADDRESS: Webb Idaho.

FORM V. S. No. 5-25 M. 1-19 JAN 16 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68871

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. Culdesac Jn Vicinity St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jane Lawyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH: (Month) (Day) (Year)

7. AGE: 54 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF Father

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Maxwell

(Address) Lapwai Idaho.

15. Filed Sept 1929 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17 (Day) 1929 (Year) 746

17. I HEREBY CERTIFY, That I attended deceased from May 5 1929 to 19, that I last saw her alive on May 5 - 1929, and that death occurred on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Died in ambulance on way to Hospital.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George Gaignard M. D.

9/17/1929 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL 19

20. UNDERTAKER: Vassar Undertaking Co. Lewiston Ida.

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. JAN 1 6 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce
City of Near Lapwai Idaho.

Registration District No. 128
Primary Registration District No.
(No. Culdesac & Vicinity)

State File No. 68872
Local Registrar's No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dessa Wood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH: (Month) (Day) 1851 (Year)

7. AGE: 78 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF Father

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph McConville
(Address) Lapwai, Idaho.

15. Filed Nov. 1929 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH 31

16. DATE OF DEATH: Nov. (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 18 - 1929, to Nov. 18 - 1929, that I last saw him alive on Nov. 18 - 1929, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George Gaignard M. D.
12/6/1929 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lapwai Cemetary
DATE OF BURIAL: Nov. 20 - 1929

20. UNDERTAKER: Brower - Wann
ADDRESS: Lewiston Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-1 JAN 16 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68873

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce

near City of Juliaetta Idaho.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. Culdesac & Vicinity St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Daniel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: (Month) (Day) 1883 (Year)

7. AGE: 46 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF Father: Pops-te-mo-ne-kin

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Lydia Daniel

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Corbett B. Lawyer
(Address) Lapwai Idaho.

15. Filed Nov. 1929 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH 90

16. DATE OF DEATH: Nov. (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 2 - 1929, to Nov. 12 - 1929, that I last saw him alive on Nov. 12 - 1929, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Mytral Regurgitation

(Duration) yrs. 4 mos. 9 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George Gaignard M. D.

12/6 1929 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetary

DATE OF BURIAL: Nov. 16/1929

20. UNDERTAKER: Brower-Winn

ADDRESS: Lewiston Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. REC'D JAN 16 1930 **CERTIFICATE OF DEATH**

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69871

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce

City of Lapwai Idaho.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. Culdesac & Vicinity)

2. FULL NAME Joseph Albert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6. DATE OF BIRTH

(Month) (Day) 1858 (Year)

7. AGE 71 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Invalid

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF Father

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amelia Albert

(Address) Lapwai Idaho.

15.

Filed Nov. 1929 George Gaigmard M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 31

Nov. (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 24 1928, to Nov. 12 1929, that I last saw him alive on Nov. 12 1929 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. 12 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George Gaigmard M. D.

12/6/1929 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sweetwater Cemetary

DATE OF BURIAL Nov. 15/1929

20. UNDERTAKER Brower-Wann

ADDRESS Lewiston Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19- REC'D JAN 16 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Nez Perce
City of Spalding Idaho.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128
Primary Registration District No.
(No. St.)

State File No. 66875
Local Registrar's No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Philip Franks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Indian 4/4
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: Dec (Month) 2 (Day) 1928 (Year)

7. AGE: Yrs. 11 Mos. 6 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF Father: Jonas Franks

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Louise Blackhawk

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jonas Franks
(Address) Spalding Idaho.

15.
Filed Nov. 1929 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11 - 1929. to Nov. 8 - 1929
that I last saw him alive on Nov. 8 - 1929
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) yrs. 1 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) George Gaignard M. D.
Nov. 1929 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spalding Cemetary — DATE OF BURIAL: Nov. 9 1929

20. UNDERTAKER: Graber-Wann — ADDRESS: Lewiston Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19 RECEIVED JAN 16 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 68876

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce

City of Culdesac Idaho.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. Culdesac & Vicinity St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sahtatekiket (Mary Moffet)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	Indian 4/4	Widowed

6. DATE OF BIRTH

..... 1858
(Month) (Day) (Year)

7. AGE

71 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Invalid

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Lapwai Idaho.

10. NAME OF Father Ke-kee-mas-allen

11. BIRTHPLACE OF FATHER (State or Country) Kamiah Idaho.

12. MAIDEN NAME OF MOTHER Tom-lah

13. BIRTHPLACE OF MOTHER (State or Country) Lapwai, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Gaigmard M.D.

(Address) Culdesac Idaho.

15.

Filed Oct 1929 George Gaigmard M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/29/29 19..., **to** 10/1/29 19..., **that I last saw h[illegible] alive on** 10/1/29 19..., **and that death occurred on the date stated above, at** 11:00 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaigmard M. D.

Oct 1929 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mission Cemetery — **DATE OF BURIAL** Oct 4 1929

20. UNDERTAKER Brewer-Wann — **ADDRESS** Lewiston Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

JAN 16 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of Lapwai

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. Culdesac & Vicinity St.)

State File No. 68877

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mike Grass

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: December 23 1912 (Month) (Day) (Year)

7. AGE: 16 Yrs. 9 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Montana

10. NAME OF Father: John Grass

11. BIRTHPLACE OF FATHER (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo O Keck

(Address) Lapwai, Idaho

15. Filed Sept 1929 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH 31

16. DATE OF DEATH: September 26 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11 1927, to Sept 26 1929, that I last saw him alive on Sept 26 1929, and that death occurred on the date stated above, at 3 15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

9/26 1929 (Signed) Geo O Keck M. D.

(Address) Lapwai Idaho

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 11 mos. 15 days. In the State 1 yrs. 11 mos. 15 ds.

Where was disease contracted if not at place of death? Montana

Former or usual residence Montana

19. PLACE OF BURIAL OR REMOVAL: Fort Lapwai Sanatorium

DATE OF BURIAL: 9/27 1929

20. UNDERTAKER: Institution

ADDRESS: Lapwai, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 13 1930

Label.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68878

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No.
Primary Registration District No.
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME Grace Blake 96

(a) Residence. No. 1310 - 7th Ave 1009 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Patrick Blake

6. DATE OF BIRTH (month, day and year)

7. AGE Years 61 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Dont know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Joe Blake.
(Address) Lewiston Idaho.

15. Filed Jan 1, 1930 Susan E Brine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1929, to Dec 21, 1930.
that I last saw her alive on Dec 21, 1930
and that death occurred, on the date stated above, at 7 a.m. m.
The CAUSE OF DEATH* was as follows:
Acute Cardiac dilatation.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Flu - pneumonia.
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Signs
(Signed) William L. Hall, M. D.
, 19 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho — Date of Burial 12/23 1929

20. Undertaker Vassar Mortuary — Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68879

PLACE OF DEATH
County of Nez Perce
City of Near Lewiston

Registration District No. 95
Primary Registration District No. 1009
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Gus D. Thiessen

(a) Residence. No. Lower Cemmany St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. , mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) [illegible] 14, 1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	4	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) General farming
(c) Name of employer self

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant
(Address)

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 19th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6th, 1929, to Dec 19th, 1929
that I last saw h~~im~~ alive on Dec 6th, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Jejunal obstruction
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Cancer of Stomach existing
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~~~
Did an operation precede death? Date of Feb 1929
Was there an autopsy? no
What test confirmed diagnosis? Operation
(Signed) L. C. Carnahan, M. D.
Dec 20th, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	12/21 1929
20. Undertaker	Address
Swan Mortuary	Lewiston

N. B.—Every item or information should be carefully supplied. AGE should be stated EXACTLY, and should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Carrsow

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68880

PLACE OF DEATH

County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

188 C

2. FULL NAME David James Watson Somerville.

(a) Residence. No. 807 — 8th Ave. ~~St.~~
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 10/16/1869

7. AGE Years 60 Months 2 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Episcopal Minister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cork County Ireland.

PARENTS

10. NAME OF FATHER — Somerville
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Margaret Watson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Robt Somerville
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 28th 1929
(Month) (Day) (Year)

17. I HEREBY ~~CERTIFY~~, That I attended deceased from Dec 28, 1929, to Dec 28th, 1929
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 10:04 P m.
The CAUSE OF DEATH* was as follows:

Bronchial Fracture of Skull
(duration) ..... yrs. ..... mos. — ds.

CONTRIBUTORY (Secondary) Auto accident
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Pressure symptoms
(Signed) J. C. Carrsow, M. D.
12/31, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 12/31, 1929

20. Undertaker Brown-Wann Co
Address Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68881

PLACE OF DEATH
County of Nez Perce
City of Near Lewiston

Registration District No. 95
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

101a

2. FULL NAME Satirah Ann Osborn

(a) Residence. No. ..... St. La Grande Oregon
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 14-1848

7. AGE Years 81 Months 2 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N.Y.

PARENTS
10. NAME OF FATHER David K. McDowell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.
12. MAIDEN NAME OF MOTHER Malinda Marvin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant Mrs C. W. Mumford.
(Address) Willowa, Oregon

15. Filed Dec 28, 1929 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 28th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22nd, 1929, to Dec 28th, 1929
that I last saw her alive on Dec 28th, 1929
and that death occurred, on the date stated above, at 1:30 P. m.
The CAUSE OF DEATH* was as follows:

B Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza
..... (duration) ..... yrs. ..... mos. 6 ds.

18. Where was disease contracted if not at place of death? ——
Did an operation precede death? No Date of ——
Was there an autopsy? No
What test confirmed diagnosis? Consolidation of Lobe Lung
(Signed) D. C. Carssow, M. D.
12/28, 1929 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Summerville Or. Date of Burial: 12/30 1929

20. Undertaker: Brower - Dann Co Lewiston, Idaho Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68882

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.

PLACE OF DEATH
County of Nezperce
City of Lewiston
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Virginia Smith

31

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm Smith

6. DATE OF BIRTH (month, day and year) Aug 26 1891

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	38	4		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER John W Parsons
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Nancy Debord
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14. Informant Chas Parsons, (Brother)
(Address) Cloverland, Wash.

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1929, to Dec 26, 1929
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at 11-30 P m.
The CAUSE OF DEATH* was as follows:
Pulmonary T.B.
(duration) 1 yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) Same
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? — Date of
Was there an autopsy? No What test confirmed diagnosis? Confirmed Symptoms
(Signed) E. L. White, M. D.
12-28, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cloverland, Wash	12/29/29 19

20. Undertaker	Address
H R Merchant	Clarkston Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BIND

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68883

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 76
Primary Registration District No. 1009
(No. St Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Cecil Wayne Mills

(a) Residence. No. 1239, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 22, 1929

7. AGE: Stillborth — Years | Months | Days | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lewiston Idaho

PARENTS

10. NAME OF FATHER: Otis C. Mills
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Knoxville Ky.
12. MAIDEN NAME OF MOTHER: Irma Sumerland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Keller Wash.

14. Informant
(Address) Otis Mills

15. Filed Jan 1, 1930 1239 Idaho-Lewiston Simon E. Brice Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 22 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1929, to Dec 22, 1929
that I last saw him alive on Stillbirth, 19
and that death occurred, on the date stated above, at 30 m.
The CAUSE OF DEATH* was as follows:
Premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? X Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) B. Stockslager, M. D.
12/23, 1929 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho — Date of Burial: 12/23 1929

20. Undertaker: Brown Hance Co. — Address: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68884

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. 1112 - 8th St)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Irene Porter Remington
(a) Residence. No. 1112 - 8th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank M. Remington

6. DATE OF BIRTH (month, day and year): 9/3/1854

7. AGE: Years 75 | Months 9 | Days 14 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Silverton Oregon

PARENTS
10. NAME OF FATHER: John Porter
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ky
12. MAIDEN NAME OF MOTHER: Annie White.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Mrs. Ed Patwin
(Address) Lewiston Idaho.

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Dec 17, 1929
that I last saw her alive on Dec 17, 1929
and that death occurred, on the date stated above, at 12 noon m.
The CAUSE OF DEATH* was as follows:
Organic heart disease.
several years (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic nephritis
several years (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Lab. tests.
(Signed) Paul V. Johnson, M. D.
12/19, 1929 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	12/20 1929

20. Undertaker: Brower-Wann Co. Address: Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68885

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No. 1616

PLACE OF DEATH

County of Nez Perce
City of Lewiston
(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wm Smith

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
4 days		4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work x
(b) General nature of industry, business, or establishment in which employed (or employer) x
(c) Name of employer x

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS

10. NAME OF FATHER Wm Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Virginia Parsons
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Mrs Rush Parsons
(Address)

15. Filed Dec 16, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1929, to Dec 16, 1929
that I last saw him alive on Dec 16, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Premature - 6½ months.
Rupture of amniotic sac.
(duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Unknown
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? - Known hopeless.
(Signed) E. L. White, M. D.
12-16, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Austin Cty Wash	1929
20. Undertaker	Address
Wm Parsons	Clarkston Wash

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68886

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Mary McManmus

(a) Residence. No. Lewiston Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 2 1917

7. AGE	Years	Months	Days	If LESS than 1 day,
	12	4	9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS

10. NAME OF FATHER Thomas McManmus
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn.
12. MAIDEN NAME OF MOTHER Margaret Kiely
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Thomas McManmus
(Address) Lewiston Idaho

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 13th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11th 1929, to Dec 13 1929
that I last saw h[illegible] alive on Dec 13th 1929
and that death occurred, on the date stated above, at 6:15 p.m.
The CAUSE OF DEATH* was as follows:

General Peritonitis
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Ulcer Bowel
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Dysentery Amoeba
(Signed) [illegible], M. D.
Dec 14th 1929 (Address) Lewiston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	12/16 1929
20. Undertaker	Address
Vassar Mortuary	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68887

Local Registrar's No. 113

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1099

(No. St. Joseph's Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ronald Keeler Martin

(a) Residence. No. Kendrick St. Kendrick Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): July 13 1929

7. AGE: Years — Months 5 Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Genesee Idaho.

PARENTS

10. NAME OF FATHER: York Martin

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Helen Keeler

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho.

14. Informant: Mrs York Martin
(Address): Kendrick Idaho.

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929, to Dec 15, 1929
that I last saw him alive on Dec 15, 1929
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:

Fibro Intestinal.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Mal nutrition. (marasmus.)

(duration) yrs. 9 mos. ds.

18. Where was disease contracted if not at place of death? [redacted]

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L White, M. D.

12-18, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	12/16 1929
20. Undertaker	Address
Cassan McEuen	Lewiston Ida.

RECEIVED JAN 13 1930

Clark

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68888

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.

PLACE OF DEATH

County of Nezperce,
City of Lewiston,
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

117

2. FULL NAME Jennilea Elizabeth Boyd

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Aug. 8, 1920

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
9	4		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Peck, Ida.

PARENTS

10. NAME OF FATHER Sidney James Boyd
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Myrtle Humphrey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oklahoma

14. Informant Mrs S J Boyd
(Address) Nezperce, Ida.

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7, 1929, to Dec 8, 1929
that I last saw h alive on Dec 8, 1929
and that death occurred, on the date stated above, at 1/4 a m.
The CAUSE OF DEATH* was as follows:
Appendicitis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) General Septicemia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 12/8/29
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W O Clark, M. D.
12/9, 1929 (Address) Jenston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nezperce, Ida	19

20. Undertaker	Address
H R Merchant	Clarkston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68889

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

44B

2. FULL NAME Frank R Pingree

(a) Residence. No. 129-18th Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Prudence Pingree

6. DATE OF BIRTH (month, day and year) July 31 1861

7. AGE Years 68 Months 4 Days 8 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Lewiston Dray Co.

9. BIRTHPLACE (city or town) (State or country) Wis

PARENTS
10. NAME OF FATHER Frank Pingree
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Claire Pingree
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Dec 8, 1929
that I last saw him alive on Dec 8, 1929
and that death occurred, on the date stated above, at 7 35 p.m.
The CAUSE OF DEATH* was as follows:
Endo + Myocarditis
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) unknown
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. White, M. D.
12-9, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho — Date of Burial 12/10 1929

20. Undertaker Tassar Mortuary Inc — Address Lewiston

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6890

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 16
Primary Registration District No. 1609
(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1610

2. FULL NAME Martina Jean McAllister

(a) Residence. No. 2108 — 13th Ave — St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 5 - 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston
(State or country) Idaho

PARENTS

10. NAME OF FATHER Harry McAllister
11. BIRTHPLACE OF FATHER (city or town) Spokane,
(State or Country) Wash.
12. MAIDEN NAME OF MOTHER Pearl Skinner
13. BIRTHPLACE OF MOTHER (city or town) Lewiston
(State or Country) Idaho

14. Informant Harry McAllister
(Address) Lewiston Idaho

15. Filed Jan 1, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 6th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5- 1929 to Dec 6th 1929
that I last saw her alive on Dec 6th 1929
and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus and prematurity
7 months.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pernicious Vomiting of Pregnancy with mother
(duration) yrs. mos. 20 ds.

18. Where was disease contracted? if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White M. D.
12/7, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	12/7 1929
20. Undertaker	Address
Brower-Wann Co	Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68891

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Samuel Adam Wright
(a) Residence. No. [illegible] St. Spalding Idaho
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie E. Wright
6. DATE OF BIRTH (month, day and year): July 4th 1862
7. AGE: Years 67 | Months 5 | Days 5 | If LESS than 1 day, ____ hrs. or ____ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS
10. NAME OF FATHER: Wm W. Wright
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Nancy Gibson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Mrs Chas Aukney
(Address) Winchester, Idaho.
15. Filed Jan 1, 1929 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 9th 1929 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec. 4 1929, to Dec 9 1929, that I last saw him alive on Dec 9 1929, and that death occurred, on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Prostate.
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. M. Hyde M. D.
Dec 10th 1929 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho. Date of Burial: 12/12 1929
20. Undertaker: Bower-Mann Co Address: Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68892

PLACE OF DEATH
County of Nez Perce
City of Lewiston Ida

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Carolina Ross
(a) Residence. No. 207 Lincoln St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Ross
6. DATE OF BIRTH (month, day and year) July 19 1857
7. AGE Years 72 Months 4 Days 16 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS
10. NAME OF FATHER William Canary
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Jeanette McKenzie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant William Ross
(Address) Deary Ida
15. Filed Jan 1, 1930 Susan E Brue Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 4 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 10th, 1929, to Dec. 4th, 1929
that I last saw her alive on Same, 1929
and that death occurred, on the date stated above, at 7 P.m.
The CAUSE OF DEATH* was as follows:
Mediastinal Carcinoma
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. F. McMahan M. D.
12-4-1929 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place ~~of Burial, Cremation~~, or Removal Troy
Date of Burial 19
20. Undertaker John Pickerd
Address Troy Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68895

PLACE OF DEATH

County of Oneida

City of ~~Malad~~ Stone

Registration District No. 26

Primary Registration District No. 2069

Local Registrar's No. 40

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Dewey Anderson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug-14-1898

7. AGE: Years 31 | Months 4 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Stone Ida.

PARENTS

10. NAME OF FATHER: Andrew Anderson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Hyrum Utah.

12. MAIDEN NAME OF MOTHER: Rose Arbon

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Snowville Utah

14. Informant ✓
(Address) Rosa Anderson

15. Filed 12/31, 1929 Stone Ida. J. M. Tarr Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec- 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1927, to Dec 25 1929

that I last saw him alive on Dec 20th 1929

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH was as follows:
Mitral & Tricuspid insufficiency

..... (duration) 9 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [signature] M. D.

12/25, 1929 (Address) Snowville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Snowville Utah | Date of Burial: Dec 28 1929

20. Undertaker: J. Guy Denson | Address: Malad Ida

FORM V. S. No. 5-A—25 M. 1-19. RECEIVED JAN 6 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida

City of St. John

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26

Primary Registration District No. 2069

(No. ..... St.)

File No. 68896

Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Ann Richards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widowed (Write the word.)

6. DATE OF BIRTH: August (Month) 20 (Day) 1850 (Year)

7. AGE: 73 Yrs. 3 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Brigham City Utah

10. NAME OF FATHER: Thomas W. Richards

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Charlotte Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Richards

(Address) Malad R.F.B. 2

15. Filed 12/31 1929 J. M. Kerns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1929 to Dec 14 1929 that I last saw him alive on Dec 13 1929 and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Insuff.

Myocarditis

(Duration) ? Yrs. ..... mos. ..... ds.

Contributory (Secondary): None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Maley M. D.

12/14 1929 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho

DATE OF BURIAL: 12-17 1929

20. UNDERTAKER: John M. Richards

ADDRESS: Logan Utah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68897

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2064

Local Registrar's No. 38

(No.) 90
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel E. Jones.

(a) Residence. No. Malad Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Hannah May Williams

6. DATE OF BIRTH (month, day and year) May 7. 1882

7. AGE	Years	Months	Days	If LESS than 1 day,
	47	7	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Malad
(State or country) Ida.

PARENTS

10. NAME OF FATHER Josphiniah Jones
11. BIRTHPLACE OF FATHER (city or town) Wales.
(State or Country)
12. MAIDEN NAME OF MOTHER Phoebe Davis
13. BIRTHPLACE OF MOTHER (city or town) Wales.
(State or Country)

14. Informant Snow Clark.
(Address) Malad Idaho

15. Filed 12/31, 1929 J. M. Nevins
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to Dec 9 , 1929
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 5 30 P.M.
The CAUSE OF DEATH* was as follows: Heart; had not been doctor, but
suffering from
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) A. A. Meba, M. D.
12/13, 1929 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. John. Ida	Dec. 15 1929
20. Undertaker	Address
J. Guy Benson	Malad Ida

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68899

PLACE OF DEATH
County of Bayette
City of Fruitland
Registration District No. 51
Primary Registration District No. 2130
Local Registrar's No. 6
(No. 129)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vernon LeRoy Shank
(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 9. 1923

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
6	5	--	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ida ho

PARENTS
10. NAME OF FATHER B. J. Shank
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Edith Lamb
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ore

14. Informant B. J. Shank
(Address) Fruitland Idaho

15. Filed Dec 10, 1929. Mrs Wm J. Drysdale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1929, to Dec 9, 1929
that I last saw him alive on Dec 9, 1929
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Chronic nephritis (Glomerular)
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? same
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical.
12/10 1929 (Signed) W. D. Reese, M. D.
(Address) Ontario, Ore.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewis Plymouth	Dec 11 1929

20. Undertaker J. W. Hagan Address Payette Ida
Johnson Furn Co

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 13 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No. 5
County of Payette
Primary Registration District No. 1009
City of ..... (No. ....., ... St.)
File No. 68900
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Sumner Lucas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 8 (Day) 1907 (Year)

7. AGE: 22 Yrs. 11 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wyoming

10. NAME OF FATHER Lee Lucas

11. BIRTHPLACE OF FATHER (State or Country) Neb

12. MAIDEN NAME OF MOTHER Eva Phillips

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Robert Lucas
(Address) Jackson Wyo -

15.
Filed Dec 13 1929 Wm J. Drysdale Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 90
Dec (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1929, to Dec 13 1929, that I last saw him alive on Dec 13 1929, and that death occured on the date stated above, at 1:50 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation & Stenosis -

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary) Cardiac Decompensation

(Duration yrs. 3 mos. ds.

(Signed) Wm J. Drysdale M. D.

12/13 1929 (Address) Mrs Plymouth Idaho -

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 30 days. In the State.....yrs.....mos. 30 days

Where was disease contracted if not at place of death? Wyoming -

Former or usual residence Jackson, Wyo -

19. PLACE OF BURIAL OR REMOVAL: Jackson Wyo - | DATE OF BURIAL: Dec 14 1929

20. UNDERTAKER: Peterson Furn & Und Co | ADDRESS: Payette Ida

F.N. Adair

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 8 1930

PLACE OF DEATH

STATE IDAHO
DEPARTMENT O PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68901

County of Power
City of Am Falls, Idaho
Registration District No. 25
Primary Registration District No. 2070
Local Registrar's No. 37
(No.) 58a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Johann Isaak

(a) Residence. No. 6 Miles south od Am Falls, St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Sophia Isaak

6. DATE OF BIRTH (month, day and year) June 30/ 1863

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10. NAME OF FATHER Ausust Isaak
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Leuise Hasse
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant Theodore H. Isaak
(Address) American Falls, Idaho

15. Filed 1 – 6, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 28th 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23, 1929, to Dec 24, 1929
that I last saw h alive on Dec 24, 1929
and that death occurred, on the date stated above, at 3 p. m.
The CAUSE OF DEATH* was as follows: Pernicious Anemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) V G Logan, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Am Falls, Ida	12/30/29

20. Undertaker Am Davis — Address Am Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

PLACE OF DEATH

County of Power

City of American Falls, Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 25

Primary Registration District No. 2072

(No. Bethony Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68902

Local Registrar's No. 36

100 a

2. FULL NAME Joe Comparoni

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 9th 1929

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Am Falls, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Joe Comparoni

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Italy

12. MAIDEN NAME OF MOTHER Hellen Mower

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Pocatello Ida.

14. Informant Helen Dumont

(Address) American Falls, Idaho

15. Filed 12-26, 1929 Emma Nolte
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 25th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23, 1929, to Dec 25, 1929

that I last saw him alive on Dec 25, 1929

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) V. G. Fagan, M. D.

12-27, 1929 (Address) Am Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
American Falls	12/26 1929

20. Undertaker	Address
A W Davis	American Falls, Ida

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68903

PLACE OF DEATH

County of Power

City of American Falls

CERTIFICATE OF DEATH

Registration District No. 25

Primary Registration District No. 2072

Local Registrar's No. 35

(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME William Virgil Walker

100a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: Years — Months 11 Days 12 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): American Falls Idaho

PARENTS

10 NAME OF FATHER: Ona V Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rockland Idaho

12 MAIDEN NAME OF MOTHER: Elena N Frodsham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Rockland Idaho

14 Informant: William Frodsham
(Address)

15 Filed 12-24, 1929 Genevieve Notts Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 22 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1929, to Dec 22, 1929, that I last saw him alive on Dec 22, 1929, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.
12-23, 1929 (Address) American Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal — Date of Burial: Dec. 1929

20. Undertaker: Family — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68904

PLACE OF DEATH
County of Power
City of American Falls
Registration District No. 21
Primary Registration District No. 2072
(No.) Local Registrar's No. 34
(If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME Sarah J. Creasey

(a) Residence. No. Two Miles East of Town St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jacob Creasey

6. DATE OF BIRTH (month, day and year) Feb 11 1844

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	10	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER William Valentine
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Amie Walworth
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant T. W. Creasey
(Address) American Falls, Idaho

15. Filed Dec 12-24, 1929 Geneva North Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 1, 1929, to Dec 21, 1929
that I last saw her alive on Dec 19, 1929
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) C. F. Blick, M. D.
12/22, 1929 (Address) Am Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F. Cemetery	12/24/29
20. Undertaker A W Davis	Address Am Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 8 1930

PLACE OF DEATH

County of Power

City of American Falls, Registration District No. 21

Primary Registration District No. 2072

(No. 7 Miles North of Am Falls)

(If death occurred in a hospital or institution, give its name instead of street and number.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68905

Local Registrar's No. 23

2. FULL NAME Herbery W. Krein

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 5th 1914

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
15	1	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Dhrist J. Krein

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.D.

12. MAIDEN NAME OF MOTHER Chrisina Kramer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant Christ J. Krein

(Address) R.F.D. American Falls, Ida

15. Filed 12/22, 1929 Genevieve Noble Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929, to Dec 21, 1929, that I last saw him alive on Dec 20, 1929, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

measles

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? none.

(Signed) M. C. Merkmon, M. D.

12-21, 1929 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Am Falls	12/ 22/29

20. Undertaker A W Davis Address Am Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1830

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68906

PLACE OF DEATH

County of Power

City of American Falls

Registration District No. 25

Primary Registration District No. 2072

Local Registrar's No. 32

(No. Bethony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Thomas Robus

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Known

6. DATE OF BIRTH (month, day and year): 1849

7. AGE: Years 80 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: Various

9. BIRTHPLACE (city or town) (State or country): New Zeland

PARENTS

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Ann Davis

(Address) American Falls, Idaho

15. Filed 12-15, 1929 Genevieve Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Dec 13, 1929

that I last saw him alive on Dec 13, 1929

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. F. Schiltz, M. D.

Dec 14, 1929 (Address) Am. Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: I.O.O.F. Cem. | Date of Burial: 12/15/29

20. Undertaker: Ann Davis | Address: Am Falls Ida

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED DEC 18 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

State File No. 68907

Local Registrar's No. 123

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME T. T. Sweet 129

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH March (Month) 21 (Day) 1857 (Year)

7. AGE 72 Yrs. 7 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired Business
(b) General nature of industry, business or establishment in which employed (or employer) Hotel Prop.

9. BIRTHPLACE (State or Country) Sportsville Penn

10. NAME OF Father Ambrose Sweet

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER Maria Buckles

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wallace Hospital

(Address) Wallace Ida

15. Filed Nov 7 1929 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1929, to Nov 5 1929 that I last saw him alive on Nov 5 1929 and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Uremia

Chr Parenchymatous Nephritis

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) Myocarditis

(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) Max T. Smith M. D.

11/6/29 19..... (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wallace Ida

DATE OF BURIAL 11-7 1929

20. UNDERTAKER Bruce J. Wardell

ADDRESS Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19. RECEIVED DEC 18 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

State File No. 68908

Local Registrar's No. 124

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donald Lee Kelly 162

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: Oct (Month) 23 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Wallace Ida.

10. NAME OF Father: Thomas Kelly

11. BIRTHPLACE OF FATHER (State or Country): Paterson New Jersey

12. MAIDEN NAME OF MOTHER: Helen Risinger

13. BIRTHPLACE OF MOTHER (State or Country): Brigham City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Providence Hospital
(Address) Wallace Ida.

15. Filed Nov 10 1929 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1929 to Nov 8 1929, that I last saw him alive on Nov 8 1929, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Marasmus

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Congenital Syphilis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

11/8 1929 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 16 days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida. DATE OF BURIAL: Nov 10 1929

20. UNDERTAKER: Bruce G. Warstell ADDRESS: Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68909

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 125

129

2. FULL NAME Bruce F. Tolbert
(a) Residence. No. Mullan, Idaho St. Mullan, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Tolbert.
6. DATE OF BIRTH (month, day and year) Oct 27-1870
7. AGE Years 59 Months 0 Days 15 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retail Lumber
(b) General nature of industry, business, or establishment in which employed (or employer) Dealer
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Mucy Penn.

PARENTS
10. NAME OF FATHER Capt Tolbert.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Not Known.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Mrs B. F. Tolbert.
(Address) Mullan, Idaho.
15. Filed Nov 15, 1929. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 12 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 5, 1929, to Nov 12, 1929
that I last saw him alive on Nov 12, 1929
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Chronic parenchymatous nephritis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. L. Quigley, M. D.
11/14/29, 19 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mullan, Idaho. Date of Burial Nov 15 1929
20. Undertaker J. A. Bever Ward, Und. Co. Address Wallace, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68910

PLACE OF DEATH
County of Shoshone
City of Murray

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 126

129

2. FULL NAME Fredrick W. Schmidt

(a) Residence. No. Murray, Idaho St. Murray Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or ~~Divorced~~ (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Katherine Schmidt

6. DATE OF BIRTH (month, day and year) Sept 7 – 1857

7. AGE Years 72 Months 2 Days 7 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9. BIRTHPLACE (city or town) (State or country) Ashland Penn

PARENTS

10. NAME OF FATHER John Schmidt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Rosalie Grosser
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs R. Schmidt
(Address) Murray, Ida.

15. Filed Nov 17, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF ~~DEATH~~ Nov 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ___, 1927, to Nov 14, 1929
that I last saw h___ alive on Nov 10, 1929
and that death occurred, on the date stated above, at 6:30 P. m.
The CAUSE OF DEATH* was as follows:
Nephritis Chr
Parenchymatous
(duration) Several yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis Chr
(duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. Moore, M. D.
11/15, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Murray, Idaho. Date of Burial Nov 17 1929

20. Undertaker J. A. Bever Ward Und. Co. Address Wallace, Ida.

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED DEC 18 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

State File No. 68911

Local Registrar's No. 127

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Doris Evelyn Needles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Dec. (Month) 11 (Day) 1908 (Year)

7. AGE: 20 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): St Thomas Ontario

10. NAME OF Father: E. E. Jaggard

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Amelia Read

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Jaggard
(Address) Burke Ida

15. Filed Nov 24 1929 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH 743

16. DATE OF DEATH: Nov (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1929 to Nov 20 1929 that I last saw her alive on Nov 20 1929 and that death occurred on the date stated above, at 6 20 P.M.

The CAUSE OF DEATH* was as follows:

Thrombosis Cerebral

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia Lobar

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Mowery M.D.

11/20 1929 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida

DATE OF BURIAL: Nov 24 1929

20. UNDERTAKER: Bruce G. Warstell

ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68912

PLACE OF DEATH
County of Shoshone
City of Mullan

Registration District No. 70
Primary Registration District No. 1011
(No. Erickson Lease - Mine acc.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 128

186

2. FULL NAME Williams B Farmer

(a) Residence. No. ..... St. Mullan, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Laura E Farmer

6. DATE OF BIRTH (month, day and year) Apr 28 - 1880

7. AGE: Years 49, Months 6, Days 21. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Erickson Lease

9. BIRTHPLACE (city or town) (State or country): N Carolina.

PARENTS

10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Not Known.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Mrs Laura E. Farmer
(Address): Mullan, Idaho.

15. Filed Nov 22, 1929. F. K. Quigley, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows: Fro Skull & neck
..... (duration) Instant yrs. mos. ds.
CONTRIBUTORY (Secondary) Cave in mine
Morning mine (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. Mowery Corone, M. D.
11/20, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mullan Idaho. Date of Burial: Nov 22 1929

20. Undertaker: J. A. Bever, Ward Mud. Co. Address: Wallace, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68913

Local Registrar's No. 129

PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 20

Primary Registration District No. 1011

(No. Providence Hosp)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME Sam John McLeod

(a) Residence. No. Red Monarch Mine St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 21 - 1865

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	10	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Red Monarch Mine.

9. BIRTHPLACE (city or town) Ontario
(State or country) Canada

PARENTS

10. NAME OF FATHER John McLeod

11. BIRTHPLACE OF FATHER (city or town) Ontario.
(State or Country) Canada

12. MAIDEN NAME OF MOTHER Mary McDonald

13. BIRTHPLACE OF MOTHER (city or town) Ontario
(State or Country) Canada

14. Informant Mrs Thurston
(Address) Mullan Idaho.

15. Filed Nov 23, 1929. F. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Nov 20, 1929
that I last saw h alive on Nov 20, 1929
and that death occurred, on the date stated above, at 7:30 P. m.
The CAUSE OF DEATH* was as follows: Tuberculosis Pulmonary
Arteriosclerosis
Cardiac Dilatation
Edema
Ascites

(duration) 1 Year mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos Mowery M. D.

11/24, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mullan Idaho	Nov 23 1929
20. Undertaker Ward & Linder	Address Wallace Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68914

PLACE OF DEATH

County of Shoshone

City of ~~Kellogg~~ Co Infirmary

Wallace

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 130

(No. County Infirmary)

(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Sidney James Fore

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Fore

6. DATE OF BIRTH (month, day and year) June 16-1845

7. AGE 84 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work M.D.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Litchfield Ill

14. Informant John L. Fore
(Address) Kellogg Ida

15. Filed Nov 22, 1929 R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1926, to Nov 21, 1929

that I last saw him alive on Nov 20, 1929

and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

..... (duration) ..... yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) Yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) James R Dean, M. D.

11/22/29, 19.. (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Ida

Date of Burial 11/23 1929

20. Undertaker R. L. Hoult

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68915

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 131

183

2. FULL NAME Thomas Cannaday
(a) Residence. No. Creston B C St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 6 - 1971

7. AGE: 18 Years | Months: 1 | Days: 16 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Homesteader
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Parks Cy. Utah

PARENTS
10. NAME OF FATHER: Lee Cannady
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Terrete Haute Ind.
12. MAIDEN NAME OF MOTHER: Mary McMullin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Heber City Utah

14. Informant: Thos McMullin
(Address): Kellogg Idaho

15. Filed Nov 24, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12, 1929, to Nov 23, 1929
that I last saw him alive on Nov 22, 1929
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows: Accidental gunshot wound of right chest.
(duration) yrs. mos. 13 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ensville Idaho
Did an operation precede death? No. Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? Autopsy findings
(Signed) W C Lindsay, M. D.
11/23, 1929 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Creston, B. C. | Date of Burial: 11/24 1929

20. Undertaker: R. L. Hunt | Address: Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68916

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 132

131

2. FULL NAME Johanna Fredstrand
(a) Residence. No. Mullan, Idaho St. Mullan.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year)

7. AGE 64 Years Months 0 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) Boarding House
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER C. Massing.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Johanna Larson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Hellen Fredstrand
(Address) Mullan, Idaho.

15. Filed Nov 27, 1929 L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to Nov 24, 1929
that I last saw her alive on Nov 23 20, 1929
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Uremia
..... (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) Chr Parenchymatous nephritis
..... (duration) ..... yrs. 6 mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phys Signs. Urine Tests
(Signed) Max T. Smith M. D.
11/25/29, 19 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane Wash. Date of Burial Nov 27 1929

20. Undertaker J. A. Bever Ward Und Co. Address Wallace, Ida.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68917

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 133

48 B

2. FULL NAME [illegible] Nash

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6. DATE OF BIRTH (month, day and year): Feb. 16th 1879

7. AGE: 50 Years, 9 Months, 8 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): England

PARENTS
10. NAME OF FATHER: Jno Nash
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Sarah Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Wm Nash
(Address): Vancouver B. C.

15. Filed Nov 27, 1929. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 24 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Nov 24, 1929
that I last saw him alive on Nov 24, 1929
and that death occurred, on the date stated above, at 4:20 p.m.
The CAUSE OF DEATH was as follows:
[illegible] Asthma
(duration) several yrs. mos. ds.
CONTRIBUTORY (Secondary): Alcoholism Chronic
(duration) several yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of .....
Was there an autopsy? None
What test confirmed diagnosis? None
(Signed) Dr. Mowery, M. D.
1/25, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace Ida
Date of Burial: Nov 27 1929

20. Undertaker: J. W. Bever for Ward Und Co
Address: Wallace Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68918

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1911
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 134
88a

2. FULL NAME Nina Lynn Lantermen
(a) Residence. No. Burke Idaho St. Burke, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May 31-1923
7. AGE 6 Years 5 Months 25 Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Salmon City Idaho

PARENTS
10. NAME OF FATHER L. F. Lantermen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Alta Pemble
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Toolsboro Iowa

14. Informant Mr L. F. Lantermen
(Address) Burke, Idaho.
15. Filed Nov 27, 1929. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 26 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1929, to Nov 26, 1929
that I last saw her alive on Nov 25, 1929
and that death occurred, on the date stated above, at 8 A. m.
The CAUSE OF DEATH* was as follows: Endocarditis Malignant
..... (duration) yrs. Several mos. ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia
..... (duration) yrs. Several mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Doris Mowery, M. D.
11/27, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace Idaho
Date of Burial Nov 27 1929
20. Undertaker J. A. Bever Ward Undertaking Co
Address Wallace, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC... DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68919

PLACE OF DEATH
County of Shoshone
City of Near Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 135

186

2. FULL NAME Lesslie Elwood Ellis.
(a) Residence. No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ruth R. Ellis.

6. DATE OF BIRTH (month, day and year) June 20-1901

7. AGE Years 28 Months 5 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Day Rock Mng. Co.

9. BIRTHPLACE (city or town) (State or country) California

PARENTS
10. NAME OF FATHER Garry Ellis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) California
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mr Henry L. Day
(Address) Wallace, Idaho.

15. Filed Nov 28, 1929. J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on ....., 19.....
and that death occurred, on the date stated above, at 10:30 a.m.
The CAUSE OF DEATH* was as follows: Crushed to death between Skip & Wall
..... (duration) Instant yrs. mos. ds.
CONTRIBUTORY (Secondary) None
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. S. Mowrey Coroner
11/27, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Los Angeles Calif. Date of Burial Shipped Nov 28 1929

20. Undertaker J. A. Beer Ward Mud Co. Address Wallace, Ida.

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6999

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 136

PLACE OF DEATH

County of Shoshone
City of Near Prichard (No.) 188 E.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David Soley

(a) Residence. No. Prichard Idaho St. Prichard, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Winton Lbr Co.

9. BIRTHPLACE (city or town) (State or country) Nova Scotia

PARENTS

10. NAME OF FATHER Chas Soley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nova Scotia
12. MAIDEN NAME OF MOTHER Sadie Faulkner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nova Scotia

14. Informant J. F. Faulkner
(Address) Post Falls, Idaho

15. Filed Dec 3, 1929. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 28 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ... 19...
and that death occurred, on the date stated above, at 10:30 a.m.
The CAUSE OF DEATH was as follows: Shock leg log crushing
Cause of operation
to death
(duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) None
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. Wood Brown, M.D.
11/30, 1929 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Nova Scotia — Date of Burial Dec 3 1929

20. Undertaker J. A. Power — Address Wallace, Idaho.
Ward Und Co.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68921

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 51

PLACE OF DEATH
County of Shoshone
City of Kellogg

(No. 162)
(If death occurred in a hospital of institution, give its name instead of street and number.)

2. FULL NAME Gladys Williams

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 4, 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
			5	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Kellogg, Idaho

9. BIRTHPLACE (city or town) (State or country) Kellogg, Idaho

PARENTS

10. NAME OF FATHER L. E. Williams

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Mabel Thornton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant Les Williams
(Address) Kellogg, Idaho

15. Filed Dec. 30, 1929. Mrs. Helen M. Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1929, to Dec 9th, 1929
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
delivery & hyderamnion. Breech

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Delivery
(Signed) W. C. Lambert, M. D.
12/16, 1929, (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Idaho	Dec 9, 1929
20. Undertaker	Address
M. P. Thornhill	Kellogg Ida

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68099

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 50
(No. 101 B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Simon Martin Marchesi

(a) Residence. No. 418 S. Division St. St.
(Usual place of abode)
Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Edna Jane Marchesi

6. DATE OF BIRTH (month, day and year) Dec 15 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	11	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work City Clerk - Justice of Peace - Notary Public
(b) General nature of industry, business, or establishment in which employed (or employer) City of Kellogg - and
(c) Name of employer Clerked at different times for Mrs. Mc Edwin

9. BIRTHPLACE (city or town) (State or country) Pueblo, Colorado

PARENTS

10. NAME OF FATHER Peter Marchesi
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Idont know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Floyd E. Marchesi
(Address) 315 Maple St - Kellogg Idaho

15. Filed Dec. 30, 1929 Mrs. Helen M. Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19, 1929, to Nov 23, 1929
that I last saw him alive on Nov 23, 1929
and that death occurred, on the date stated above, at 4.20 A. m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Dont Know.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. R. Musson, M. D.
Dec 17, 1929 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg, Idaho	Nov 26 1929
20. Undertaker M. C. Thornhill	Address Kellogg, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68923

PLACE OF DEATH
County of Shoshone
City of ——

Registration District No. 127
Primary Registration District No. 2400
Local Registrar's No. 9
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

197

2. FULL NAME Clarence Arthur Franklin
(a) Residence. No. —— Spokane Wash St. Spokane, Wash
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Estelle Ploetzke

6. DATE OF BIRTH (month, day and year) August 7-1884

7. AGE Years 38 Months 4 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumber Jack
(b) General nature of industry, business, or establishment in which employed (or employer) Lumbering
(c) Name of employer Unemployed at date of death

9. BIRTHPLACE (city or town) (State or country) Granite, Idaho

PARENTS
10. NAME OF FATHER Stone
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown
11-12-13 Unknown to informant

14. Informant Mrs. Estelle Ploetzke
(Address) Avery Idaho

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 22d (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Dec. 22d, 1929, to ——, 19..
that I last saw him ~~alive~~ dead on Dec. 22d, 1929
and that death occurred, on the date stated above, ~~at~~ probably between 12.00 + 1.15 pm.
The CAUSE OF DEATH* was as follows:
Gunshot wound - homicidal

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Hemorrhage
(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? ——
Did an operation precede death? No Date of ——
✓ Was there an autopsy? No
✓ What test confirmed diagnosis? ——
(Signed) C Busey M. D.
Dec. 22, 1929 (Address) Avery Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place ~~of Burial, Cremation,~~ or Removal St. Maries Idaho
✓ Date of Burial 19

20. Undertaker Geo. E. Mitchell
Address St. Maries Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68926

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No.) 65-a
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wm Albert Smithwick

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elva Smithwick

6. DATE OF BIRTH (month, day and year) Feb 5 1892

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	37	9	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Truck Driver
(c) Name of employer Kenneth Shark Lbr Co

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Wm Smithwick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ia
12. MAIDEN NAME OF MOTHER Flora Ann Ryman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind

14. Informant Texas Hospital
(Address) Buhl Idaho

15. Filed Dec 3, 1929 J. T. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Nov-30-, 1929
that I last saw h[illegible] alive on Nov-30-, 1929
and that death occurred, on the date stated above, at 6.50 (a)m.
The CAUSE OF DEATH* was as follows:
Myelogenous Leukemia

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? [illegible] origin
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory-blood
(Signed) F. W. MacNamara, M. D.
2-Dec-, 1929 (Address) Buhl, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl Cemetery	12/4 1929
20. Undertaker Neville & Rugg	Address Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68927

Registration District No. 39
Primary Registration District No. 2687
Local Registrar's No.

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Co. Hospital
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Gertrude Swordy

90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Stanley Swordy

6. DATE OF BIRTH (month, day and year): March 24-190

7. AGE — Years: 27 | Months: 8 | Days: 9 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Kirkwood Ill.

PARENTS

10. NAME OF FATHER: Jens Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Dora Knaus
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Don't Know

14. Informant: Lutie Machacek
(Address): Twin Falls Ida.

15. Filed Dec. 5, 1929. J. H. Wardley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 3rd 19 29
(Month) Dec (Day) 3rd (Year) 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1929, to Dec 3, 1929, that I last saw h[illegible] alive on Dec. 3, 1929, and that death occurred, on the date stated above, at 2 30 a.m.

The CAUSE OF DEATH* was as follows:
Exhaustion, acute cardiac dilatation.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Lobar pneumonia
(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death? at her home
Did an operation precede death? no Date of -
Was there an autopsy? Yes
What test confirmed diagnosis? laboratory
(Signed) F. W. MacNamara, M. D.
5 - Dec - 1929 (Address) Buhl, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl - Ida	Dec 6 19 29
20. Undertaker: L. Johnson	Address: Buhl Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68928

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. at home R.F.D.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George A Lincoln

(a) Residence. No. Twin Falls R.F.D. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 16 1861

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER George Lincoln
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't know
12. MAIDEN NAME OF MOTHER Mary Banks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Jessie E. Lincoln
(Address) 1338 6th Ave East city

15. Filed 1-7-30, 19 Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929, to Dec 28, 1929
that I last saw him alive on Dec 16th, 1929
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:
Carcinoma of liver
(duration) One yrs. mos. ds.
CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of —
Was there an autopsy? Clinical No
What test confirmed diagnosis? Clinical
(Signed) H E Lumb, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Dec 31 1929

20. Undertaker J J Grossman Address Twin Falls.

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68929

PLACE OF DEATH
County of Twin Falls.
City of Twin Falls.

Registration District No.
Primary Registration District No.
(No. Twin Falls County Hospital 124
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Nellie J. Owen
(a) Residence. No. 544 - 2nd Ave W St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of James W. Owen

6. DATE OF BIRTH (month, day and year) Jan 2 - 1889

7. AGE Years	Months	Days	If LESS than 1 day,
40	11	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bethany Missouri

PARENTS
10. NAME OF FATHER Martin V Mummaw
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Josephine Hobbs
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant James W. Owens
(Address) 544 - 2nd Ave W.

15. Filed Dec 31st, 1929 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21st, 1929, to Dec 24th, 1929, that I last saw her alive on Dec 24th, 1929, and that death occurred, on the date stated above, at 1:30 p.m.
The CAUSE OF DEATH* was as follows: Acute Nephritis

(duration) yrs. 4 mos. ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) one yrs. mos. ds.

18. Where was disease contracted if not at place of death? At Home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. E. Lamb, M. D.
Dec - 27th, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	Dec 29 1929
20. Undertaker	Address
White Mortuary, Inc	Twin Falls Ida.

Every item of this certificate should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68930

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

188a

2. FULL NAME Emil Wonnenberger
(a) Residence. No. 628 4th ave north St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 1st 1910

7. AGE 19 Years Months 3 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Alberta Canada

PARENTS
10. NAME OF FATHER Lewis Wonenberg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Maud Anderst
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Lewis Wonenberg
(Address) Twin Falls Ida

15. Filed 1-7th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31, 1929, to Dec 31, 1929
that I last saw him alive on Dec 31, 1929
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows: Concussion + Shock
(duration) yrs. mos. 3 hrs ds.
CONTRIBUTORY (Secondary) Hit by a railroad train (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Hit by train
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History of case
(Signed) H N Lutz, M. D.
1-3-, 1930 (Address) Twin Falls Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Date of Burial Jan 4 1930

20. Undertaker T C Drake Address Twin Falls

REC'D JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68931

Registration District No. ____
Primary Registration District No. ____
Local Registrar's No. ____

- PLACE OF DEATH
County of Twin Falls
City of Twin Falls
(No. ____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

144 a

2. FULL NAME Clayde Jene Curry
(a) Residence. No. Hamilton St. Montana
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 16 1907

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
22	—	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Clyde E Curry.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Bessie Paschal
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant (Hamilton Mont)
(Address) Clyde E Curry

15. Filed 1-7th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 31 (Month) (Day) 11.45 PM (Year) 1929

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows: Railroad Crossing Accident - Killed Instantly. Head Severed Body Mangled
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) Accidental death
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Decapitation
(Signed) J E Drake Coroner M. D.
Jan 2/30 19____ (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hamilton Mont	Removed Jan 3 1929

20. Undertaker J E Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 30 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68931

F.E. Drake
Coroner
Twin Falls, Idaho
Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Clayde Jene Curry who died at Twin Falls, Idaho Dec. 31, 1929
Cause of death "R.R. Crossing accident-killed instantly. Head severed--badly mangled."

Information DESIRED in order to complete certificate:

PLEASE STATE WHETHER OR NOT AN AUTO WAS INVOLVED IN THIS ACCIDENT AS WE HAVE A SPECIAL ASSIGNMENT FOR SUCH CASES.

PLEASE ANSWER BELOW:

Clyde J Curry was killed while driving a loaded AUTO truck on R R crossing about one mile south and one half ~~mile~~ east of Twin Falls city limits

SIGNED, F. E. Drake County Coroner

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC[illegible] JAN 1[illegible] 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68932

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 551 2nd Ave No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Virgil Homer Ormsby
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Mar. 4 1873
7. AGE Years 56 Months 9 Days 25 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Retail auto
(c) Name of employer Union Motor Co
9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER Volney H. Ormsby
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Ralph H. Ormsby
(Address) 551 2nd Ave No. City

15. Filed 1-7th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 29 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov-17, 1929, to Dec 29th 1929
that I last saw him alive on Dec 29th, 1929
and that death occurred, on the date stated above, at 4:55 P.m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage apoplexy.
(duration) yrs. mos. 15 ds.
CONTRIBUTORY (Secondary) Arterial Hypertension Several
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) John Coughlin M.D.
1-2, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial Dec 31 1929
20. Undertaker T. J. Grossman
Address Twin Falls

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68933

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. Co. Gen. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minnie Weekes 148

(a) Residence. (Usual place of abode) No. 138 2nd Ave E St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Mar 6 1894

7. AGE: Years 35 | Months 9 | Days 23 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: Aaron Abbey
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Marion Vandegan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Hiram Weekes
(Address) 138 2 Ave East.

15. Filed 1-7-30, 19.. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to Dec 29, 1929
that I last saw her alive on Dec 9. 1929
and that death occurred, on the date stated above, at 6:30 P. m.
The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) J. E. Langenwalter. M. D.
Jan 2, 1930 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Dec 31 1929
20. Undertaker: J. F. Sorensen — Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68934

PLACE OF DEATH

County of Twin Falls.
City of Twin Falls.

Registration District No.
Primary Registration District No.
(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

49

2. FULL NAME Lizzie Fritz
(a) Residence. No. Kimberly Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced, (write the word): Widow

5a. If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) ~~WIFE of~~ Widow of Conrad Fritz

6. DATE OF BIRTH (month, day and year) July 27-1861

7. AGE 68 Years | Months 5 | Days 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mascoutah Ill

PARENTS

10. NAME OF FATHER Henry J. Decker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mary Ann Brantzel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Emma Decker
(Address) Kimberly Ida

15. Filed 1-7th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4th, 1929, to Dec 27, 1929
that I last saw her alive on Dec 27, 1929
and that death occurred, on the date stated above, at 9:30 a.m.
The CAUSE OF DEATH* was as follows:
Carcinoma of the thyroid
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? yes Date of Dec 27. 29
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H E Lamb M. D.
Dec 28, 1929 (Address) Twin Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mascoutah, Ill | Date of Burial 19

20. Undertaker: White Mortuary Inc. | Address: Twin Falls.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68935

PLACE OF DEATH
County of Twin Falls.
City of " "

Registration District No.
Primary Registration District No.
(No. Twin Falls Co. Hospital) 108a
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Gertrude Louise McCarty
(a) Residence. No. 328 W. Sherman St. Pocatello, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of William K. McCarty.
6. DATE OF BIRTH (month, day and year) Jan. 6, 1889
7. AGE Years Forty. Months 11 Days 23 If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Colorado.

PARENTS
10. NAME OF FATHER William P. Hambitzer
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Mary Ann Boardman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mass.

14. Informant William K. McCarty.
(Address) 328 W. Sherman St. Pocatello.

15. Filed 1-7th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 30, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1929, to Dec. 30, 1929.
that I last saw her alive on Dec. 29, 1929.
and that death occurred, on the date stated above, at 6:00 a.m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia.
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Traumatism (automobile accident)
(duration) -- yrs. -- mos. 5 ds.

18. Where was disease contracted if not at place of death? Place of death.
Did an operation precede death? No Date of ——
Was there an autopsy? No.
What test confirmed diagnosis? Clinical findings.
(Signed) H. Passer, M. D.
Dec. 30, 1929. (Address) Twin Falls, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pocatello, Ida. Date of Burial 19
20. Undertaker H. L. McHan. Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68936

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.) Dr Wilson 10 0a

2. FULL NAME Dona Ilie Chadwick

(a) Residence. No. 564 39 North St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Dec 13/29

7. AGE — Years — Months — Days 13 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED —

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Tho E. Chadwick

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Carl M Thompson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Tho E Chadwick

(Address) Twin Falls.

15. Filed 1-7, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 24 11-30 1929

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1929, to Dec. 24, 1929

that I last saw her alive on Dec 24, 1929

and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H W Wilson, M. D.

Dec 30, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery

Date of Burial: Dec 25 1929

20. Undertaker: F E Drake

Address: Twin Falls

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68937

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 188
Coroner

2. FULL NAME Albert Herschel Logan

(a) Residence. No. Castleford St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 19 - 1908

7. AGE	Years	Months	Days	If LESS than 1 day,
	21	9	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Big Piney Wyo

PARENTS

10. NAME OF FATHER R. D. Logan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark.
12. MAIDEN NAME OF MOTHER Fay Hamby.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ark.

14. Informant E D Logan
(Address) Castleford Ida.

15. Filed 1-7, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — , 19— , to — , 19
that I last saw h— alive on — , 19
and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:
Automobile Accident
Car overturned on Curve
Fracture Skull and bones
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Face
died instantly
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No —
What test confirmed diagnosis?
(Signed) F. E. Drake Coroner, M. D.
Dec 26, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Dec 28 1929

20. Undertaker F. E. Drake — Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68938

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Anna Crawford Wilson

(a) Residence. No. 269 - Harrison St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 3 - 1859

7. AGE Years: 70 Months: 5 Days: 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: Benjamin Crawford

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Priscilla Davidson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant H. C. Wilson
(Address) 269 - Harrison St. Twin Falls

15. Filed Dec 31st, 1929 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30, 1929, to Dec 26, 1929
that I last saw her alive on Dec 29, 1929
and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. E. Langenwalter, M. D.
Dec 27, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery — Date of Burial: Dec 29 1929

20. Undertaker: White Mortuary Inc — Address: Twin Falls Idaho

N. B. ENG. ... NG INK—THIS IS A PERMANENT RECORD ... be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68939

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1000a

2. FULL NAME Jacob Luther Lewis

(a) Residence. No. seven miles So. East St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Laura Lewis

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	9	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Farm work.
(c) Name of employer

9. BIRTHPLACE (city or town) Missouri
(State or country)

PARENTS

10. NAME OF FATHER Jacob Lewis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Katherine
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs. Laura Lewis
(Address) Kimberly Ida R.R.2

15. Filed Dec. 31st, 1929 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1929, to Dec 19, 1929
that I last saw h~~im~~ alive on Dec 19 1929, 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H. W. Campbell M. D.
Dec 19, 1929 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida.	12-21 1929
20. Undertaker	Address
White Mortuary	Twin Falls Ida.

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68040

Registration District No. ____
Primary Registration District No. ____
Local Registrar's No. ____

PLACE OF DEATH
County of Twin Falls
City of " "
(No. at home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48a

2. **FULL NAME** Charles B. Anderson
(a) Residence. No. Twin Falls RFD #2 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 6

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	11	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Jacob Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Minna
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs. C. B Anderson
(Address) Twin Falls RFD #2.

15. Filed 1-7, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1924, 19__, to Dec 19th, 1929
that I last saw h__ alive on Dec 19th, 1929
and that death occurred, on the date stated above, at 1 p.m.
The CAUSE OF DEATH* was as follows:
Chronic valvular endocarditis
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Oedema of Lungs
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John R Coughlin, M. D.
12-20, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Dec. 21 1929
20. Undertaker	Address
T. J. Grossman	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68941

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.) 131
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Perry Haverland

(a) Residence. No. 246 South Park St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced, HUSBAND ~~of~~ (or) ~~WIFE of~~: Lelah Haverland

6. DATE OF BIRTH (month, day and year): Jan 12-1849

7. AGE: Years 80 | Months 10 | Days 29 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Businessman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: William Haverland
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Sarah Bassett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New York

14. Informant: C. Roy Haverland
(Address)

15. Filed Dec 31st, 1929 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2d, 1924, to Dec 11th, 1929, that I last saw h~~im~~ alive on Dec 11th, 1929, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:
Uremia -
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H E Trunk, M. D.
Dec 11th 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Fall Cemetary	12-13 1929
20. Undertaker	Address
White Mortuary	Twin Falls Ida

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68942

PLACE OF DEATH
County Twin Falls
City of Twin Falls
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.) 149 C
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frances Vincent Murphy
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Murphy

6. DATE OF BIRTH (month, day and year) June 17, 1908

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	5	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER J A Murphy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill
12. MAIDEN NAME OF MOTHER Lizabeth Graver
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ky

14. Informant Lawrence Murphy
(Address) Twin Falls

15. Filed Dec 31 51, 1929 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9, 1929, to Dec 9, 1929
that I last saw him alive on Dec 9, 1929
and that death occurred, on the date stated above, at 10 30 a.m.
The CAUSE OF DEATH* was as follows:
Fracture of skull
by automobile accident
accidental.
(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) C. Russell Weaver M. D.
12-12, 1929 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Dec 12 1929

20. Undertaker J E Drake Address Twin Falls

N. B.—Every item of information should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68943

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No. Dr Weaver 101a
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Marri Corzdoba
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 12

7. AGE 37 Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Panama

PARENTS
10. NAME OF FATHER Eward Donato
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Marri Donato
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Panama

14. Informant Dudocia Cordoba
(Address) Twin Falls Ida

15. Filed 1-7th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1st, 1929, to Dec. 6, 1929
that I last saw her alive on Dec 5, 1929
and that death occurred, on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Asthma
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E. D. Weaver, M. D.
12/10, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Date of Burial Dec 8 1929

20. Undertaker J. Drake Address Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68944

PLACE OF DEATH

County Twin Falls

City of Hollister

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

11 B

2. FULL NAME Lee Hoskins

(a) Residence. No. Hollister St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug 29 / 29

7. AGE Years: — Months: III Days: 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: M D Hoskins

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ore

12. MAIDEN NAME OF MOTHER: Rosemary Park

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: M D Hoskins

(Address): Hollister

15. Filed Dec. 31st, 1929 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 5 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1929, to Dec 5, 1929

that I last saw him alive on Dec 5, 1929

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

influenza

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H W Clouchet M. D.

Dec 5, 1929 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery

Date of Burial: Dec 7 1929

20. Undertaker: F C Drake

Address: Twin Falls

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68945

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Lamay Wonacott Jr.

(a) Residence. No. Home 3½ miles S.E. Twin Falls St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 20 - 1909

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	7	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Estacada
(State or country) Oregon

PARENTS

10. NAME OF FATHER Edward Wonacott
11. BIRTHPLACE OF FATHER (city or town) Illinois
(State or Country) Ill.
12. MAIDEN NAME OF MOTHER Addie Hardin
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Oregon

14. Informant Edward Wonacott
(Address) Kimberly, Ida.

15. Filed 12-30, 1929 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28, 1929, to Dec 2, 1929
that I last saw h-im alive on Dec. 2, 1929
and that death occurred, on the date stated above, at 6 20 a.m.
The CAUSE OF DEATH* was as follows:
Influenza
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H. R. Wilson M. D.
Dec 3, 1929 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Twin Falls Cemetery	
20. Undertaker	Address
White Mortuary Inc	Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68946

PLACE OF DEATH
County of Twin Falls
City of 1 1 11

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. Co Gen Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME William T Breckon

(a) Residence. No. Kimberly St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	9	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Real estate
(b) General nature of industry, business, or establishment in which employed (or employer) County Comissioner
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER John Breckon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Hart
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Richard Breckon
(Address) Ontario Ore

15. Filed Dec 30 1929 Christen J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1929, to Nov 26 1929
that I last saw him alive on Nov 24 1929
and that death occurred, on the date stated above, at 3 a.m.
The CAUSE OF DEATH* was as follows:
Chronic Cardio-Vascular-renal disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? clinical
(Signed) J. E. Davis, M. D.
Nov 27, 1929 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Nov 29 1929
20. Undertaker P. J. Grossman	Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-29 RECEIVED JAN 10 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 13
Primary Registration District No.
File No. 00943
Registered No.

1. PLACE OF DEATH
County of Valley
City of Cascade Ida (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Infant) Williams
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 19 (Day) 1929 (Year)

7. AGE: ....Yrs. ....Mos. 1 ds.
IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cascade Idaho

10. NAME OF FATHER: John Williams

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Ethel Jordan

13. BIRTHPLACE OF MOTHER (State or Country): Star Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cascade. Ida
(Address) John Williams

15. Filed 12/19 1929 Stella Cain Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 161a
December (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1929 to Dec 19 1929
that I last saw h. alive on Dec 19 1929
and that death occurred on the date stated above, at 3:00 A.M.
The CAUSE OF DEATH* was as follows:
Premature infant

(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.
(Signed) Forest G Ward M. D.
12/19 1929 (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cascade Idaho
DATE OF BURIAL: Dec 19 1929

20. UNDERTAKER: W. W. Bratney
ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 6[illegible]50

PLACE OF DEATH
County of Valley
City of McCall

CERTIFICATE OF DEATH
Registration District No. 75
Primary Registration District No.
(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mary E Farrell

(a) Residence. No. New Meadows St. 74a
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
69	8	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dallas Tex

PARENTS
10 NAME OF FATHER Noel Jones
11 BIRTHPLACE OF FATHER (city or town) (State or country) North Car
12 MAIDEN NAME OF MOTHER Kuch
13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Car

14 Informant J. W. Farrell
(Address) McCall, Idaho

15 Filed 12/4, 1929 Stella Crim Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 23 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased ~~from~~ 12/23 1929, ~~to~~ after death 19..., that I ~~last~~ saw her alive on ..., 19..., and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Sudden)
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Senility degeneration.
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Objective symptoms.
(Signed) Don [illegible], M. D.
..., 19... (Address) McCall, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: New Meadows Idaho — Date of Burial: Dec 26 1929

20. Undertaker: Wm H Brown — Address: Boise Idaho

A Rose

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

68977

DO NOT WRITE IN THIS SPACE
State File No. 68977

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

79

2. FULL NAME Oliva Edmonia Williams

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 28, 1855

7. AGE Years 74 Months 9 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas

PARENTS
10. NAME OF FATHER Mr. Fortner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER no inf.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant O. V. Little
(Address) 5 0 2 Division St

15. Filed Jan. 30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH Mason

16. DATE OF DEATH Dec (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1929, to Dec 19, 1929
that I last saw her alive on Dec 18, 1929
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:
anginal - Pectoris
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) High Blood pressure
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) T. R. Mason, M. D.
Dec 21, 1929 (Address) Kellogg, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg, Idaho — Date of Burial Dec 22 1929

20. Undertaker M. C. Thornhill — Address Kellogg, Idaho

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69010

Local Registrar's No. 2

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

(No. 3040 Madison St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Marsh.

(a) Residence. No. 3040 Madison St.
(Usual place of abode)
Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

14a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Maria Marsh.

6. DATE OF BIRTH (month, day and year) January 7th 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	11	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Mining Man.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England.

PARENTS

10. NAME OF FATHER Joe Marsh.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.

12. MAIDEN NAME OF MOTHER Martha Opinshaw.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Claude Marsh.

(Address) Boise, Idaho.

15. Filed 1-3, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 30th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30th, 1929, to Dec 30th, 1929
that I last saw h. alive on Dec 30th, 1929
and that death occurred, on the date stated above, at 7:55 AM m.

The CAUSE OF DEATH* was as follows:

Apoplexy -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) High Blood pressure

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Rhodes M. D.

12/31/29 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 1/3/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED FEB 1 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Adams

City of Mesa

Registration District No. 86

Primary Registration District No. 1010

(No. ..... St.)

File No. 69029

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Maried (Write the word.)

6. DATE OF BIRTH. Aug (Month) 10 (Day) 1865 (Year)

7. AGE 64 Yrs. 4 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W B McFall

(Address) Mesa. Idaho

15. Filed Dec 15th 1929 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1929, to Dec 10th 1929, that I last saw him alive on Dec 10th 1929, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.

..... 19..... (Address) Mesa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Council Ida

DATE OF BURIAL Dec 14 1929

20. UNDERTAKER J A Hudelson

ADDRESS Cambridge Ida

SYMS - YORK CO., PTRS. & SGRS. 24654

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69042

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5736

PLACE OF DEATH

County of Bannock
City of Pocatello
(No. Paca. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert T. Kulp. 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Georgia

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Dr. P. C. Ray.
(Address) Paca. Idaho

15. Filed Jan 2, 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Dec 31, 1929
that I last saw h[illegible]live on Dec 30, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Bronchial Asthma
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) P. C. Ray M. D.
1-1, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Idaho — Date of Burial Jan 2, 1929

20. Undertaker: H. L. McGhan — Address: Paca. Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69043

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 1
(No. 6 miles N. W. of City)
Local Registrar's No. 5735
129

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles G. Havens

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 17, 1853

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
76.	2	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer New York State

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Wm. Havens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Ann Drew
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant W. P. Havens
(Address) Pocatello, Idaho

15. Filed Jan 3, 1930 M Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
12-28, 1929, to 12-30, 1929
that I last saw h... alive on 12-28, 1929
and that death occurred, on the date stated above, at N 9 m.
The CAUSE OF DEATH* was as follows:
Nephritis & Myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) M Young M. D.
1/3, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salamanca N.Y.	Jan 3 1930

20. Undertaker R. L. McHan Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Delayed for information.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69071

PLACE OF DEATH
County of Bingham
City of Firth Idaho

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 2
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

71a

2. FULL NAME Herth Miles

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 30 - 1929

7. AGE Years | Months 6 | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Babe
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Firth Idaho

PARENTS

10. NAME OF FATHER A. H. Miles
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kane Co. Utah
12. MAIDEN NAME OF MOTHER Ada Neubauer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Paris Bear Lake Co. Idaho

14. Informant A. H. Miles
(Address) Firth Idaho

15. Filed Dec 28, 1929 Mrs Hattie E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 25 — 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1929, to Dec 25, 1929
that I last saw him alive on Dec 25 - (7 P.M.) 1929
and that death occurred, on the date stated above, at 10 P.M. m.
The CAUSE OF DEATH* was as follows:
Meningitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Don't know
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. E. Chest, M.D.
Dec 28, 1929 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Firth. Idaho. | Date of Burial 19

20. Undertaker | Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Delayed for information.

RECEIVED FEB 6 1980

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69072

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

74a

2. FULL NAME Lavina L. McCoy (McCoy)

(a) Residence. No. South Meridian St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: W. E. McCoy

6. DATE OF BIRTH (month, day and year): Dec 4 1871

7. AGE: Years 58 | Months X | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Clarence Iowa

PARENTS

10. NAME OF FATHER: James G. Walton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Emily Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: O. B. Neumann
(Address): Blackfoot Ida

15. Filed Dec 18, 1929 Mrs Hattie E. Tabor Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ 12-16, 1929, to ....., 19....
that I last saw her alive on 12-16, 1929
and that death occurred, on the date stated above, at 11:30 A.m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (duration) ..... yrs. ..... mos. 2 hrs.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? physical findings
(Signed) J. O. Hampton M. D.
12-17, 1929 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery | Date of Burial: Dec 19 1929

20. Undertaker: E. J. Peck | Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69104

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 19

204

2. FULL NAME Lola Bowman
(a) Residence. No. 334 - 6th Street St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 19, 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work (New born child)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER Wesley Earl Bowman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden, Utah
12. MAIDEN NAME OF MOTHER Mattie Barnes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rigby, Idaho R.2

14. Informant Wesley E. Bowman
(Address) 334 - 6 Street Idaho Falls, Idaho

15. Filed Dec 25, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 19 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929, to Dec 19, 1929
that I last saw her alive on Dec 19, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Puerperal Exhaustion & Compression of Cord
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Posterior Delivery
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Delivery Manual Date of 12/19/29
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) [signature], M. D.
12/19, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby, Ida. Route 2
Date of Burial: Dec. 21 1929

20. Undertaker: Jack A. Wood
Address: Idaho Falls, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69126

Registration District No. 59
Primary Registration District No. 2129
Local Registrar's No. 13

PLACE OF DEATH

County of Butte
City of Martin
(No. Near Martin, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Ole Andersen

(a) Residence. No. Near Martin, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not definitely known

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) South Dakota

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Joe L. Martin
(Address) Arco, Idaho

15. Filed Dec 16, 1929 F. C. Ball Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) About 1st (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Suicidal by
Dynamite explosion
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Edwin Hucker Coroner
Dec 14, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Arco Idaho	Dec. 14 1929
20. Undertaker	**Address**
Theo R. Garner	Mackay, Ida.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69161

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. Caribou Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

190

2. FULL NAME Jane S. Smith
(a) Residence. No. Soda Springs Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced ~~HUSBAND of (or) WIFE of~~

6. DATE OF BIRTH (month, day and year) July 12 - 1913

7. AGE Years 15 Months 8 Days 26 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hi School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Thatcher Ida

PARENTS
10. NAME OF FATHER Ernest H. Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Thatcher Ida
12. MAIDEN NAME OF MOTHER Cecelia L. Short
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St Anthony Ida

14. Informant Ernest H. Smith
(Address) Soda Springs Ida

15. Filed 4-8-, 1929 Dr. Russell Tizart Registrar
(Last)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7, 1929, to April 7, 1929, that I last saw he alive on April 7, 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:
Heart failure during Chemical Nevrosis
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Organic Heart Disease
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of —
Was there an autopsy? 0
What test confirmed diagnosis? —
(Signed) Eric Kaschy, M. D.
4-8-, 1929 (Address) Soda Springs Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida | Date of Burial Apr. 9 1929

20. Undertaker C. L. Whitman | Address Soda Springs Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69163

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Alfred Serhune 74a

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 13, 1874

7. AGE — Years: 55 — Months: 3 — Days: 17 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Druggist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: John Serhune
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Mrs C A Serhune
(Address) Burley Ida

15. Filed 2/15, 1930 F. N. Carter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1929, to Dec 31, 1929
that I last saw him alive on Dec. 31, 1929
and that death occurred, on the date stated above, at 7.45 A. m.
The CAUSE OF DEATH* was as follows:

[redacted]
Appendicitis.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Appendicitis
(Signed) Dan Schultz M. D.
12/31, 1929 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burley Ida — Date of Burial: Jan. 2 1930
20. Undertaker: D. C. Johnson — Address: Burley

RECEIVED FEB 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69183

Registration District No. 35
Primary Registration District No. 2021
Local Registrar's No.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH
County of Elmore
City of near King Hill

2. FULL NAME William H. Ferguson

(a) Residence. No. near King Hill Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Margaret Ferguson

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	11	13.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Jacob Ferguson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Francis Humble
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Margaret Ferguson
(Address) King Hill Idaho

15. Filed 1-20, 1930 Mrs Mary Sullivan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1929, to Nov 20, 1929
that I last saw him alive on Nov 20, 1929
and that death occurred, on the date stated above, at 11:30 a m
The CAUSE OF DEATH* was as follows:

Myocarditis
(duration) ..... yrs. ..... mos. ..... ds

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) M. J. Evangelinos, M. D
Nov 20, 1929 (Address) Glenns Ferry

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or Removal	Date of Burial
Glenns Ferry Ida	11-22 1930
20. Undertaker	Address
G C Zacher	Mt Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. E-25M. 1-19

RECEIVED FEB 12 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69199

Local Registrar's No. 314

Registration District No. 99

Primary Registration District No. 2177

1. PLACE OF DEATH

County of Fremont

City of St. Anthony

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clayton M. Winkler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Nov. (Month) 17 (Day) 1858 (Year)

7. AGE: 71 Yrs. — Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF Father: Enoch Winkler

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Rachel Barton

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Nettie Winkler
(Address) St. Anthony Idaho

15. Filed Dec 17 1929 W M Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1929, to Dec 16 1929, that I last saw him alive on Dec 16 1929, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis and general arteriosclerosis.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) several yrs. ..... mos. ..... ds.

(Signed) D A Ellison M. D.

12/17 1930 (Address) St. Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St. Anthony — DATE OF BURIAL: Dec. 18 1929

20. UNDERTAKER: W M Hansen — ADDRESS: St. Anthony Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69200

PLACE OF DEATH
County of Fremont
City of Teton

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No. 3/3
100a

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dee Lyon Baker

(a) Residence. No. Teton St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 12-1928

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	5	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Teton Idaho

PARENTS

10. NAME OF FATHER John Franklin Baker

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Teton Idaho

12. MAIDEN NAME OF MOTHER Mary M. Lyon

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Morgan Utah

14. Informant John Franklin Baker
(Address) Teton Idaho

15. Filed Dec 7-, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1st, 1929, to Dec. 1st, 1929
that I last saw him alive on Dec. 1st, 1929
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Lung findings
(Signed) P. M. Keller, M. D.
Dec. 6, 1929 (Address) St Anthony Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Teton	Dec. 10th 1929

20. Undertaker W. M. Hansen | Address St Anthony Idaho

FORM V. S. No. 5-A-25M. 1-19. REC'D FEB 12 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69201

Local Registrar's No. 312

1. PLACE OF DEATH
County of Fremont
City of Parker
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary A Bassett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6. DATE OF BIRTH: August (Month) 4 (Day) 1854 (Year)

7. AGE: 75 Yrs. 3 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Leckwish S. Wales

10. NAME OF Father: Thomas Bassett

11. BIRTHPLACE OF FATHER (State or Country): South Wales

12. MAIDEN NAME OF MOTHER: Margaret Edwards

13. BIRTHPLACE OF MOTHER (State or Country): South Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Sarah Baker
(Address): Parker Idaho

15. Filed Dec. 3rd 1929 C.W. Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw her alive on Dec. 2nd 1929,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Had no doctor. Was dead when I arrived.
"Heart-Trouble"
(Duration) 12 yrs. ..... mos. ..... ds.
Contributory (Secondary): Old age
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W.M. Hansen Coroner M.D.
12/2 1929 (Address) St Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Hexburg Idaho	Dec. 5 1929
20. UNDERTAKER	ADDRESS
C.W. Hansen	St Anthony Idaho

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69202

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 311

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

184

2. FULL NAME Elliott Cottrell

(a) Residence. No. St. Anthony Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (~~or WIFE of~~) Mary M. Cottrell

6. DATE OF BIRTH (month, day and year) May 16-1889

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	40	8	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Joseph Cottrell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Sarah Ann Bowman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) America

14. Informant Mary M. Cottrell
(Address) St. Anthony Idaho

15. Filed Nov. 30 1929 Wm Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1929, to Nov. 30, 1929
that I last saw ~~him~~ alive on Nov. 30, 1929
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Peritonitis

(duration) yrs. mos. 11 ds.
CONTRIBUTORY (Secondary) Appendicitis
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of Nov. 22,
Was there an autopsy? yes
What test confirmed diagnosis? Oper. Findings.
(Signed) P. M. Kelly, M. D.
Nov. 30 1929 (Address) St. Anthony, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, Removal~~	Date of Burial
Ora Cemetery	Dec. 3 1929
20. Undertaker	Address
W. M. Hansen	St. Anthony Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69203

PLACE OF DEATH
County of Fremont
City of St. Anthony

Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 310
(No.) 196
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lyman William Butler

(a) Residence. No. St. Anthony Idaho St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 1 - 1884

7. AGE	Years	Months	Days	If LESS than 1 day,
	44	10	26	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mound City Mo.

PARENTS

10. NAME OF FATHER James A. Butler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Cora Clements
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Laurel W. Butler
(Address) St. Anthony Idaho

15. Filed Nov. 26, 1929 W. W. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 26 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Dec.~~ on Nov. 26, 1929, to , 19 , that ~~I last saw him alive on~~ he was dead when I arrived and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Unexplained. Man was working with wire said to be carrying an electric current at time of sudden death. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) T. A. Ellison, M. D.
, 19 (Address) St. Anthony Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation, or~~ Removal	Date of Burial
Council Bluffs Iowa	Nov 30 1929

20. Undertaker	Address
W. W. Hansen	St. Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69204

PLACE OF DEATH
County of Fremont
City of St. Anthony

Registration District No. 99
Primary Registration District No. 2177
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 207

46

2. FULL NAME Lillian Armenta Simons

(a) Residence. No. St. Anthony Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 4 - 1875

7. AGE Years 54 Months — Days 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Mount Pleasant Utah
(State or country)

PARENTS

10. NAME OF FATHER Nelson Tidwell
11. BIRTHPLACE OF FATHER (city or town) America
(State or Country)
12. MAIDEN NAME OF MOTHER Polly Reynolds
13. BIRTHPLACE OF MOTHER (city or town) America
(State or Country)

14. Informant Dean Simons
(Address) St. Anthony Idaho

15. Filed Oct 30, 1929 C O W Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1929, to Oct. 29, 1929
that I last saw her alive on Oct. 29, 1929
and that death occurred, on the date stated above, at 9:15 a. m.
The CAUSE OF DEATH* was as follows:
Cancer of uterus
(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of 1928
Was there an autopsy? No
What test confirmed diagnosis? Oper. Tumor
(Signed) P. M. Kelly M. D.
Oct 29, 1929 (Address) St. Anthony, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ashton
Date of Burial Nov. 1st 1929

20. Undertaker W M Hansen
Address St. Anthony Ida

FORM V. S. No. ~~16-25 M. 1-10.~~ FEB 12 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69205
Local Registrar's No. 306

1. PLACE OF DEATH
County of Fremont
City of St. Anthony
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth Kelley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Nov. (Month) 21 (Day) 1912 (Year)

7. AGE: 17 Yrs. 11 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF Father: O. M Kelley MD

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Susan Grosbeck

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J A Ellerson
(Address): St. Anthony Ida.

15. Filed Oct. 30 1929 A W Hansen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 29 (Day) 1929 (Year) 101a

17. I HEREBY CERTIFY, That I attended deceased from Oct. 28 1929. to Oct. 29 1929
that I last saw her alive on Oct. 29 1929
and that death occurred on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J A Ellerson M. D.
10/30 1929 (Address) St. Anthony Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ REMOVAL: American Falls Idaho DATE OF BURIAL: Nov. 1 1929

20. UNDERTAKER: A W Hansen ADDRESS: St. Anthony Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69206

Local Registrar's No. 202

PLACE OF DEATH

County of Fremont

City of St. Anthony.

Registration District No. 99

Primary Registration District No. 2177

(No. 749)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Smith

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 1st 1854.

7. AGE: Years 75 | Months 1 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Garage Man

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10. NAME OF FATHER: Not Known.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not Known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Nell Smith Schreiber

(Address) St Anthony.

15. Filed Oct. 30, 1929 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 28th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 5th, 1929 to Oct. 28, 1929

that I last saw him alive on Oct. 26, 1929

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Brights

(duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Findings

(Signed) P. W. Kelly, M. D.

10-28-, 1929 (Address) St. Anthony, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parker Ida.	Oct. 30 1929
20. Undertaker	Address
Dean J. Keller	Rigby

FORM V. S. No. 5-A—25 M. 1-19. FEB 12 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fremont

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

(No. ..... St.)

File No. 69207

Registered No. 302

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Edward Mason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct 8 (Month) (Day) 1868 (Year)

7. AGE: 61 Yrs. 11 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Morgan Utah

10. NAME OF FATHER: James H Mason

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Clara Hardley

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Raymond L. Mason

(Address) St Anthony R F D 3

15. Filed Oct. 8 1929 Wm Hansen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 6 (Day) 1929 (Year) 90

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

"Organic Heart Disease Mitral regurgitation"

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Discovered about three yrs ago

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W B West M. D.

..... 19..... (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parker Idaho

DATE OF BURIAL: Oct. 8 1929

20. UNDERTAKER: Vern J Keller

ADDRESS: Rexburg

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69208

PLACE OF DEATH
County of Fremont
City of New Dale

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No. 301

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myrtle Elizabeth Cuttler 44

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edwin H. Cuttler

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	—	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) At home.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clement Grove Utah.

PARENTS

10. NAME OF FATHER James T. Thorne
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Clement Grove, Utah
12. MAIDEN NAME OF MOTHER Harriet Farnsworth
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Clement Grove Utah

14. Informant Edwin H. Cuttler
(Address) New Dale, Idaho

15. Filed 9/30, 1929 W. M. Ransen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 29 (Day) – 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-15-, 1927, to 9-22, 1929
that I last saw her alive on 9-22-, 1929
and that death occurred, on the date stated above, at 3:30 A.M.
The CAUSE OF DEATH* was as follows:
Metastatic Carcinoma of Liver + Lungs following amputation of Breast - 1927 (duration) 2 yrs. 9 mos. ds.
CONTRIBUTORY (Secondary) Malnutrition
(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of 2-1927
Was there an autopsy? Yes
What test confirmed diagnosis? Microscopic
(Signed) Edwin Cuttler, M. D.
9/29, 1929 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clement Grove Utah	Oct 2. 1929

20. Undertaker Tom L. Keller Address Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69209

PLACE OF DEATH
County of Fremont
City of St.Anthony

Registration District No. 99
Primary Registration District No. 2177

Local Registrar's No. 300

(No. 129)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Conrad Abegglen

(a) Residence. No. St.Anthony Idaho R.F.D. #1 St.
(Usual place of abode)
Length of residence in city or town where death occurred. 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Magdalena Abegglen

6. DATE OF BIRTH (month, day and year) June 6th, 1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	3	15	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9. BIRTHPLACE (city or town) Switzerland
(State or country)

PARENTS

10. NAME OF FATHER Conrad Abegglen

11. BIRTHPLACE OF FATHER (city or town) Switzerlan
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Kummer

13. BIRTHPLACE OF MOTHER (city or town) Switzerland
(State or Country)

14. Informant Magdalena Abegglen
(Address) St.Anthony Idaho R.F.D. #1

15. Filed 9/23/1929, 19.. W. M. Hansen
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 22nd, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1929, to Sept 20, 1929
that I last saw h.. alive on Sept 20, 1929
and that death occurred, on the date stated above, at .. m.
The CAUSE OF DEATH* was as follows:
Nephritis - chronic interstitial.
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Cardio vascular renal disease
(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms & clinical findings

(Signed) Lorin S. Rich, M. D.
9-24, 1929 (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burial Wilford	9/24 1929
20. Undertaker	**Address**
W. M. Hansen	St.Anthony, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-12 FEB 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69210
Local Registrar's No. 296

1. PLACE OF DEATH
County of Fremont
City of St. Anthony
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Asa Lorenzo Bagley.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH: Feb. (Month) 11 (Day) 1912 (Year)

7. AGE: 17 Yrs. 6 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wilford Idaho

10. NAME OF Father: Asa Calvin Bagley

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Jane Ophelia Mowry

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T.A. Ellison
(Address) St. Anthony Idaho

15. Filed Aug. 19 1929 W.M. Hansen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1929 to Aug. 17 1929, that I last saw him alive on Aug 16 1929, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Endocarditis
and Myocarditis
(Duration) 10 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T.A. Ellison M. D.
8/17 1929 (Address) St. Anthony Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wilford — DATE OF BURIAL: Aug. 19 1929

20. UNDERTAKER: W.M. Hansen — ADDRESS: St. Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69211

PLACE OF DEATH
County of Fremont
City of Egin

Registration District No. 99
Primary Registration District No. 2177
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 298

49

2. FULL NAME James Campbell Jr.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Ellen Campbell

6. DATE OF BIRTH (month, day and year) July 22-1868

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	1.	18.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Farm Laborer
(c) Name of employer

9. BIRTHPLACE (city or town) American Fork.
(State or country) Utah.

PARENTS

10. NAME OF FATHER James Cambell Sr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland.
12. MAIDEN NAME OF MOTHER Elizibith Burnside
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland.

14. Informant Mrs James Campbell.
(Address) St. Anthony Route #3.

15. Filed Sept. 12, 1929 James Hansen
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 10 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929 to Sept. 10, 1929
that I last saw him alive on Sept. 5, 1929
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Cancer of Eye & Head
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Gen'l Exhaustion
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Microscope
(Signed) P. M. Keller, M. D.
9-10, 1929 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parker Ida.	Sept. 12. 1929.
20. Undertaker Vern L. Keller.	Address Rigburg.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-15 FEB 12 530

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69212

Local Registrar's No. 297

1. PLACE OF DEATH

County of Fremont

City of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bonnie Sue Jacobs.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Infant.

6. DATE OF BIRTH: Sept. 24 (Month) (Day) 1928 (Year)

7. AGE: Yrs. 11 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St. Anthony, Ida.

10. NAME OF Father: Glen Jacobs.

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ella Andrew.

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Jacobs.

(Address) St. Anthony Idaho

15. Filed Aug. 24 1929 O. W. Hansen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 19 1929. to Aug 22 1929, that I last saw her alive on Aug 22 1929, and that death occurred on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Allison M. D.

8/22 1929 (Address) St. Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St. Anthony | DATE OF BURIAL: Aug. 24 1929

20. UNDERTAKER: O. W. Hansen | ADDRESS: St. Anthony Ida

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69213

PLACE OF DEATH
County of Fremont
City of St. Anthony

Registration District No. 99
Primary Registration District No. 2177
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 299

90

2. FULL NAME Robert Davis Jr.
(a) Residence. No. Not Known St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Known

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 54 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Not Known

PARENTS
10. NAME OF FATHER: Robert Davis Sen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Henry Richman
(Address) St. Anthony #1 Idaho

15. Filed Sept. 17, 1929 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 17 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1929, to Sept. 17, 1929
that I last saw him alive on Sept. 17, 1929
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Acute Cardiac Dilitation
..... (duration) ..... yrs. ..... mos. 1 hr.
CONTRIBUTORY (Secondary) ✓
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? History
(Signed) C. M. Keller, M. D.
Sept. 17, 1930 (Address) St. Anthony Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Anthony | Date of Burial: Sept. 20 1929

20. Undertaker: W. M. Hansen | Address: St. Anthony Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69219

Local Registrar's No. 304

PLACE OF DEATH

County of Lemhi

City of Stanley

Registration District No. 99

Primary Registration District No. 2177

(No. 204)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Beby Birch

(a) Residence. No. Stanley St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of /

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Stanley Idaho

PARENTS

10. NAME OF FATHER Parley W. Birch

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bear Lake Co Utah

12. MAIDEN NAME OF MOTHER Edna Child

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Riverdale Utah

14. Informant Parley W. Birch
(Address) Wilford

15. Filed 10/29, 1929 Wm Hanscom Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1929 to Oct. 28, 1929
that I last saw him alive on Oct. 28, 1929
and that death occurred, on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:
Premature Birth

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Placenta Previa Marginalis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of -
Was there an autopsy? No.
What test confirmed diagnosis? Birth
(Signed) P. W. Keller, M. D.
10-28, 1929 (Address) Stanley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wilford Ida.	Oct 29 1929
20. Undertaker	**Address**
Wm J. Keller	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69220

PLACE OF DEATH
County of Fremont
City of Stanthy

Registration District No. 99
Primary Registration District No. 2177
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 305

149

2. FULL NAME Elva Augusta Child Munsee Birch
(a) Residence. No. Stanthy Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Feamal
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Parley Birch

6. DATE OF BIRTH (month, day and year)

7. AGE Years 42 Months 3 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Riverdale Utah

PARENTS
10. NAME OF FATHER H. T. Child
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Riverdale Utah
12. MAIDEN NAME OF MOTHER Flora Wadsworth
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rooper Utah

14. Informant H. T. Child
(Address) Shelley Idaho

15. Filed Oct 29, 1929 O M Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 28th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1929, to Oct 28, 1929
that I last saw her alive on Oct. 28, 1929
and that death occurred, on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows:
Placenta Previa
(duration) ..... yrs. 8 mos. ..... ds.
CONTRIBUTORY (Secondary) Pregnancy
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Finding of delivery
(Signed) P. M. Keller, M. D.
10-28-1929 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wilford Ida — Date of Burial Oct 29 1929
20. Undertaker Vern J. Keller — Address Rexburg

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

FEB 12 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Fremont

City of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

(No. ..... St.)

State File No. 69221

Local Registrar's No. 308

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Marion Birch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Many

6. DATE OF BIRTH: Nov (Month) 2 (Day) 1929 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 4 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Wilford Idaho

10. NAME OF Father: Melvin Birch

11. BIRTHPLACE OF FATHER (State or Country): Wilford Idaho

12. MAIDEN NAME OF MOTHER: Rosa Belle Family

13. BIRTHPLACE OF MOTHER (State or Country): Wilford Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T A Ellison

(Address) .....

15. Filed Nov. 3rd 1929 W M Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

161a

16. DATE OF DEATH: Nov (Month) 2 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1929, to ..... 19....., that I last saw her alive on Nov 2 1929, and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Premature Birth.
(7 months)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T A Ellison M. D.

11/2 1929 (Address) St. Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Welford

DATE OF BURIAL: Nov. 3 1929

20. UNDERTAKER: W M Hansen

ADDRESS: St. Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED FEB 12 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69222

Local Registrar's No. 376

Registration District No. 99

Primary Registration District No. 2177

1. PLACE OF DEATH
County of Fremont
City of St. Anthony
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elezabeth Ann Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: April 20 (Month) (Day) 1870 (Year)

7. AGE: 59 Yrs. 8 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Swansey South Wales

10. NAME OF Father: Phomas Thomas

11. BIRTHPLACE OF FATHER (State or Country): South Wales

12. MAIDEN NAME OF MOTHER: Katherine Morgan

13. BIRTHPLACE OF MOTHER (State or Country): South Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Nellie Barnett
(Address): Shelley Idaho

15. Filed Dec. 24 1929 Wm Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 23. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20 1929. to Dec. 23 1929,
that I last saw her alive on Dec. 23 1929,
and that death occurred on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:
Acute Yellow Atrophy of Liver
(Duration) ..... yrs. 1 mos. 15 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. W. Keller M. D.
Dec 23 1929 (Address) St Anthony, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL OR REMOVAL~~: Milford Idaho
DATE OF BURIAL: Dec 27 1929

20. UNDERTAKER: Wm Hansen
ADDRESS: St. Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69223

PLACE OF DEATH
County of Fremont
City of St. Anthony

Registration District No. 2177
Primary Registration District No. 99
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 315

170

2. FULL NAME John Davis Jenkins

(a) Residence No. St. Anthony Idaho St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Cherry Jenkins

6. DATE OF BIRTH (month, day and year) March 9-1889

7. AGE: Years 40, Months 9, Days 11. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labour
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: None

9. BIRTHPLACE (city or town) (State or country): Egin Idaho

PARENTS
10. NAME OF FATHER: Ephraim W. Jenkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country): South Wales
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Mrs Mary Jenkins
(Address) St. Anthony Idaho

15. Filed Dec. 21, 1929. W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 20th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1929, to Dec. 20, 1929
that I last saw him ~~alive on~~ Dead on Dec. 20 1929
and that death occurred, on the date stated above, at 9.40 a. m.
The CAUSE OF DEATH* was as follows:
Suicide
Shot-gun
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ✓ ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? Yes
What test confirmed diagnosis? Findings
(Signed) P. M. Kelly, M. D.
Dec. 20, 1930 (Address) St. Anthony, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Parker Idaho — Date of Burial: Dec. 22 1929

20. Undertaker: W. M. Hansen — Address: St. Anthony Idaho

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69229

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001

Local Registrar's No. 1

(No.) 49
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Otto Abeling

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	-	-	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER —
11. BIRTHPLACE OF FATHER (city or town) (State or Country) —
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant C. G. Hunbrock
(Address) Grangeville Ida.

15. Filed 2-3-, 1930 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Dec 14, 1929
that I last saw h alive on Dec. 14, 1929
and that death occurred, on the date stated above, at 3-9 m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Enlarged Heart, Pains
(Signed) B. Chipman, M. D.
12-17-, 1929 (Address) B Chipman

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Idaho	12-18-1929

20. Undertaker	Address
Hunbrock Mort. Co	Grangeville Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REC'D JAN 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69234

Registration District No. 106
Primary Registration District No. 2184
(No.)
Local Registrar's No. 287

PLACE OF DEATH

County of Idaho
City of Kooskia

(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME James M. Stuart

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Indian	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Harriet Stuart

6. DATE OF BIRTH (month, day and year) September 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Civil Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spokane Wash.

PARENTS

10. NAME OF FATHER James Stuart
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Susan Hollendeclair
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not

14. Informant Harriet L Stuart
(Address) Kooskia - Idaho.

15. Filed Dec 29, 1929 J M Verbeke Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept- 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Have deceased before one, 19
that I last saw h alive on July 20, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Cancer of prostate,
(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of -
Was there an autopsy? Do not know
What test confirmed diagnosis? Clinical and physical
(Signed) Fredrick Wesley Orr, M. D.
Dec 19, 1929 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fort Church - Kamiah	Oct 2 1929
20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69235

PLACE OF DEATH
County of Idaho
City of Stites

Registration District No. 106
Primary Registration District No. 2184
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 288

90

2. FULL NAME Angelia Minerva Hall

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Chas Wesley Hall

6. DATE OF BIRTH (month, day and year) Sept 15-1849

7. AGE Years 80 Months 3 Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chicago Illinois

PARENTS

10. NAME OF FATHER Unknown - Ball
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Louis Hall
(Address) Stites Idaho

15. Filed Dec 16, 1929 J M Verbeekmans Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9, 1929, to Dec 15, 1929
that I last saw her alive on Dec 14, 1929
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Aneurism of aorta

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Age
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) H W Wentworth, M. D.
Dec 16, 1929 (Address) Stites

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Stites — Date of Burial Dec 16 1929

20. Undertaker Geo Tenney — Address Kooskia

REC'D JAN 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69236

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
Local Registrar's No. 289

(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nancy Pell

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John G. Pell

6. DATE OF BIRTH (month, day and year) June 16 1852

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	6	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Crawfordville — Oregon

PARENTS

10. NAME OF FATHER Richard Finley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Polly Ann Kirk

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tennessee

14. Informant Cornie A Pell
(Address) Kooskia — Idaho.

15. Filed Dec 23, 1929 J M Verbeckmus Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Dec 22, 1929
that I last saw her alive on Dec 22, 1929
and that death occurred, on the date stated above, at 8 10 P m.

The CAUSE OF DEATH* was as follows:
Chronic diffuse Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Exam. Urine

(Signed) J M Verbeckmus, M. D.
Dec 23 1929 (Address) Kooskia

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Battle Ridge Cemetery	19
20. Undertaker	Address
Geo Tremary	Kooskia Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69237

Local Registrar's No. 290

PLACE OF DEATH

County of Idaho

City of Stites

Registration District No. 106

Primary Registration District No. 2184

(No. 74A)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lizzie Stephens

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Indeoie	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Stephen Kohl Kohl Jones

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about-78			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Moyese

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Edna Mode

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Alzeta Stephens
(Address) Stites Idaho

15. Filed Dec 24, 1929 J M Verbeckmoes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1929, to Dec 24, 1929, that I last saw her alive on Dec 24, 1929, and that death occurred, on the date stated above, at 7:15 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas. Verbeckmoes, M. D.

Dec 24, 1929 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Stites - Family Cemetery	Dec 26 1929
20. Undertaker	Address
Dan Feeney	Kooskia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69238

PLACE OF DEATH
County of ~~Italy~~ Kootenai
City of ~~Santa Cruz~~ Harrison
~~Del Sanino~~

Registration District No. 126
Primary Registration District No. 2304
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10-1929

122

2. FULL NAME Eugenie Monti
(a) Residence. No. Harrison Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 79 Years | Months: 4 | Days: | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Italy, Santa Cross Samino

PARENTS
10. NAME OF FATHER: Do not know
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Do not know
12. MAIDEN NAME OF MOTHER: Do not know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Do not know

14. Informant: V. S. B. Montie
(Address) Harrison

15. Filed Dec. 7, 1929 H. K. Barkerd, M.D. (M.) Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to 12-6-, 1929
that I last saw him alive on 12-5, 1929
and that death occurred, on the date stated above, at 3 9 m.
The CAUSE OF DEATH* was as follows: Cirrhosis of liver
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary): Mitral regurgitation
(duration) unknown yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. Wilson Reed, M.D., M. D.
12-6-, 1929 (Address) Harrison I

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Harrison Ida | Date of Burial: 12-7 1929

20. Undertaker: Cassedy Funeral Home | Address: Harrison

...PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69239

PLACE OF DEATH
County of Kootenai
City of near Harrison

Registration District No. 126
Primary Registration District No. 2304
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9 — 1925

205-B

2. FULL NAME Frank Jackson
(a) Residence. No. Squaw Bay on lake Coeur d'Alene Ida
(Usual place of abode) N.P.O. — P.O. probably Harrison Ida or Conkling Park Ida
St. (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE Caucasian
5. Single, Married, Widowed, or Divorced (write the word) Not known X
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X
6. DATE OF BIRTH (month, day and year) X
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
He said he was past 75 yr. old
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Used to be a Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer) was a county charge
(c) Name of employer none
9. BIRTHPLACE (city or town) (State or country) X

PARENTS
10. NAME OF FATHER X
11. BIRTHPLACE OF FATHER (city or town) (State or Country) X
12. MAIDEN NAME OF MOTHER X
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) X

14. Informant Virgil E. Guenther
(Address) Conkling Park Ida, or Harrison Ida

15. Filed 11-28, 1929 H R Bankerd. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~that I never saw him alive that~~ never, 19..., 19..., 19..., the informant ~~that I~~ last saw him alive on Nov. 26, 1929 and that death occurred, on the date stated above, at some time during the night preceeding 27th
The CAUSE OF DEATH was as follows:
Not known
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) has had rheumatism for years - badly crippled etc.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) H R Bankerd Registrar M. D.
11-28, 1929 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Harrison Cemetery — Date of Burial 11-28 1929
20. Undertaker Cassedy Funeral home — Address Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 9 1930

69239

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.....

PLACE OF DEATH

County of Kootenai

City of Sandpoint

Registration District No. 126

Primary Registration District No. 2304

Local Registrar's No.....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Jackson

(a) Residence. No..... St.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Don't know

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Past 75			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant.....

(Address)

15. Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from the ....., 19..... to ....., 19.....
that I last saw h.. alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Rheumatism

.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ....., M. D.

....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

Kind record of a death which seems not to have been reported. This is a copy of Dr. Wilson's book of time.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69245

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1650
Local Registrar's No. 6

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

4 4 B

2. FULL NAME Frank D. Vosburg

(a) Residence. No. County Hospital St.
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W.	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Do not know

PARENTS
10. NAME OF FATHER " " "
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant C. B. Nelson
(Address) Rathdrum Idaho

15. Filed 1-24, 1930 A. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1928, to Decbr 31, 1929
that I last saw h[im] alive on Decbr. 31, 1929
and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
about 3
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Interstitial Nephritis
with Dropsy about 1 (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Frank Ploss, M. D.
1/2, 1930 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Grove Cemetery Rathdrum	1-3 1930
20. Undertaker Woodey Funeral Home	Address Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19. JAN 22 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Helmer

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

File No. 69274

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edgar Richard Wilkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married. (Write the word.)

6. DATE OF BIRTH: June (Month) (Day) 1869 (Year)

7. AGE: 60 Yrs. 3 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Store keeper

(b) General nature of industry, business or establishment in which employed (or employer): Store

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: James L. Wilkins

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Eliza

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Floyd Lawrence

(Address) Bovill, Ida.

15. Filed Sept. 4 1929 E. B. Flasher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 1 (Day) 1929 (Year) 90

17. I HEREBY CERTIFY, That I attended deceased from 8/22 1929, to 9/1 1929, that I last saw him alive on 8/31 1929, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows: Cardiac decompensation

(Duration) 0 Yrs. 0 mos. 20 ds.

Contributory (Secondary) Auricular fibrillation unknown

(Duration) yrs. mos. ds.

(Signed) Walter R Werelius M. D.

9/2 1929 (Address) Bovill, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow

DATE OF BURIAL: 9/3 1929

20. UNDERTAKER: F. R. Short

ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 25 M. 1-19. REC JAN 2 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 69275
Registered No.

1. PLACE OF DEATH
County of Latah
City of Bovill
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 66
Primary Registration District No. 2148

2. FULL NAME James Burns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Single~~ (Write the word.)

6. DATE OF BIRTH: (Month) (Day) 1864 (Year)

7. AGE: 65 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woodsman
(b) General nature of industry, business or establishment in which employed (or employer): Lumbering

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Watt
(Address) Bovill, Idaho.

15. Filed July 25 1929 E. B. Flasher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1929 to July 23 1929 that I last saw him alive on July 23 1929, and that death occurred on the date stated above, at 7 10 P.M.

The CAUSE OF DEATH* was as follows:
Acute dilitation of heart following chronic valvular heart disease
(Duration) Yrs. 6 mos. ds.
Contributory (Secondary): Not known
(Duration) yrs. mos. ds.

(Signed) Walter F. Merrifield M. D.
19 (Address) Bovill, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 23 yrs. mos. days. In the State 23 yrs. mos. days
Where was disease contracted if not at place of death? unknown
Former or usual residence Bovill, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash. DATE OF BURIAL: July 27 1929

20. UNDERTAKER: E. M. Irwin ADDRESS: Palouse Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STERN-YORK CO., PRINTERS & BINDERS, BOISE 51087

RECEIVED JAN 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69276

PLACE OF DEATH
County of Latah
City of Bovill

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mecheal Honig
(a) Residence. No. Clarkia, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1884

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mable Lena Honig

6. DATE OF BIRTH (month, day and year): Jan 15-19

7. AGE: Years 28, Months 5, Days 27. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: mechanic
(b) General nature of industry, business, or establishment in which employed (or employer): automobile
(c) Name of employer: Henry Ford Plant

9. BIRTHPLACE (city or town) (State or country): Austria Hungary

PARENTS
10. NAME OF FATHER: Mecheal Honig Sr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Austria Hungary
12. MAIDEN NAME OF MOTHER: Maklalena Haiman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Austria Hungary

14. Informant: Mrs. Mecheal Honig
(Address): St Maries Ida

15. Filed July 16, 1929. E. [illegible] Flasher, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1929, to July 12, 1929 that I last saw him alive on July 12, 1929 and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:
Accidental (In Truck which was hit by train)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Hyden Hancher, M. D.
July 15, 1929 (Address) Bovill - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Woodlawn St Maries
Date of Burial: July 14 1929

20. Undertaker: [illegible] for [illegible] Mitchell
Address: St Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED FEB 10 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lewis — Registration District No. 47

City of Nezperce Idaho — Primary Registration District No. ____

(No. ____, ____ St.)

File No. 6927

Registered No. 146

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Elmer Andrew Brask

If death occurred in a hospital, institution or camp, give its NAME, instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 24 (Day) 1911 (Year)

7. AGE: 18 Yrs. 1 Mos. 17 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Nezperce Idaho

10. NAME OF FATHER: Theodore Brask.

11. BIRTHPLACE OF FATHER (State or Country): Wise

12. MAIDEN NAME OF MOTHER: Katherine Thode

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mr. Theodore Braach
(Address) ____

15. Filed Feb 2 1930 — Albert Huff, Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 11 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 191__, to ____ 191__, that I last saw h__ alive on ____ 191__, and that death occured on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Accidental gun shot while hunting dear self inflicted severd femoral Artery

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Albert Huff Coroner M. D.

19__ (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Nezperce Idaho — DATE OF BURIAL: Nov 13 1929

20. UNDERTAKER: Albert Huff — ADDRESS: Nezperce Idaho

FORM V. S. No. 5-25 M. 1-16-13 RECEIVED FEB 10 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lewis

City of Nezperce Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 47

Primary Registration District No.

(No. ..... St.)

File No. 69278

Registered No. 147

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Halley Marilla Chandler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Ds.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH. Jan (Month) 30 (Day) 1869 (Year)

7. AGE 60 Yrs. 10 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wisc.

10. NAME OF FATHER Henry L. Beach

11. BIRTHPLACE OF FATHER (State or Country) Eastern States

12. MAIDEN NAME OF MOTHER Thoefa Elnora Hakes

13. BIRTHPLACE OF MOTHER (State or Country) Eastern States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Chandler

(Address) Nez Perce Idaho

15. Filed ~~Feb 7 1930~~ Albert Huff Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 19 6 Pm

Nov (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-30 1929, to 11-30 1929, that I last saw her alive on 11-30 1929, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Algina pectoris

12 Hours (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) None

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) E Taylor M. D.

11 20 1929 (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Nezperce Idaho — DATE OF BURIAL Nov 13 1929

20. UNDERTAKER Albert Huff — ADDRESS Nezperce Idaho

SYMS - YORK CO., PTRS. & SDRS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED FEB 10 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 47
County of Lewis
Primary Registration District No.
City of Nezperce Idaho (No. , St.)
File No. 69279
Registered No. 148
If death occurs away from usual residence, give facts called for under special information. Rout 1
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Hines

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. August 27 1872 (Month) (Day) (Year)

7. AGE: 57 Yrs. 2 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Molty Co. Ill.

10. NAME OF FATHER: Geo Hines

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Griffin

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) x G. F. Hines
(Address) x Nezperce Idaho

15. Filed Feb 2 1930 Albert Huff Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 19 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h...alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Crawled through window when drunk
Cut both Popliteal artery
+ Vein bleed to death

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Albert Huff Coroner M. D.
19... (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce Catholic Cemetery — DATE OF BURIAL: Nov 21 1929

20. UNDERTAKER: Albert Huff — ADDRESS: Nezperce Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69292

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2016
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

100a

2. FULL NAME Dale Edward Tracy

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 22 1928

7. AGE: Years 1, Months 1, Days 28. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ~~[illegible]~~
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Heyburn Ida

PARENTS

10. NAME OF FATHER Henry Tracy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Yost Utah
12. MAIDEN NAME OF MOTHER Belva Heiner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Morgan Utah

14. Informant Henry Tracy
(Address) Burley Ida

15. Filed 12-26, 1929 E H Ehmer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 19 1929 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1929, to Dec 19, 1929
that I last saw him alive on Dec 19, 1929
and that death occurred, on the date stated above, at 2:a m.
The CAUSE OF DEATH* was as follows:
Bronchi Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Hugh E Dean, M. D.
Dec 23, 1929 (Address) ~~Hugh~~ Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Heyburn Ida — Date of Burial: Dec. 22 1929

20. Undertaker: D. E. Johnson — Address: Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECE... FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPA...

State File No. 69293

PLACE OF DEATH

County of Minidoka

City of Heyburn

Registration District No. 19

Primary Registration District No. 2015

Local Registrar's No. 162

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nora Warner

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State...

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ...

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 19 1929

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Heyburn Ida

PARENTS

10. NAME OF FATHER Wallace Deloss Warner

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Olive Christensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arizona

14. Informant W.D.Warner
(Address) Heyburn Ida

15. Filed Nov 30, 1929 E W Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1929, to Nov 21, 1929
that I last saw her alive on Nov 21, 1929
and that death occurred, on the date stated above, at 6 A M
The CAUSE OF DEATH* was as follows:
Intra Uterus
Asphyxia
..... (duration) ..... yrs. ..... mos. 24 h.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. .....

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E Dean
Nov. 22, 1929 (Address) Burley Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOL... CAUSES, state (1) MEANS AND NATURE OF INJURY, and whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Heyburn Ida	Nov. 21-29
20. Undertaker	Address

RECEIVED JAN 16 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

69294

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Spalding or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Tok-toe-tson-my (Jane Lawyer) 74

(a) Residence. No. Spalding, Ida St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	1/4 Nez Perce Indian	Divorced

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Jim Jack

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	75	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Nez Perce Reservation
(State or country) Idaho

PARENTS

10 NAME OF FATHER Koyamahsumkin
11 BIRTHPLACE OF FATHER (city or town) Nez Perce Reserve
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Tsitskoop
13 BIRTHPLACE OF MOTHER (city or town) Nez Perce Reserve
(State or country) Idaho

14 Informant Dr. George Gaignard
(Address) Culdesac, Idaho

15 Filed Sept. 17, 1929 F. M. Maxwell REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1929

17 I HEREBY CERTIFY, That I attended deceased from
----------, 19----, to ----------, 19----,
that I last saw h---- alive on ----------, 19----,
and that death occurred, on the date stated above, at ----------m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Died in ambulance on way to hospital
---------- (duration) ---- yrs. ---- mos. ---- ds.
CONTRIBUTORY (SECONDARY) ----------
---------- (duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted
If not at place of death? ----------
Did an operation precede death? ---- Date of ----------
Was there an autopsy? ----------
What test confirmed diagnosis? ----------
(Signed) Dr. George Gaignard, M.D.
, 19 (Address) Culdesac, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Lapwai Cemetery	Sept. 19 1929
20 UNDERTAKER	ADDRESS
Vassar Mortuary Co	Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

RECEIVED JAN 16 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

69295

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Slickpoo or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Iahtotekikt (Mary Moffett) 74a
(a) Residence. No. Slickpoo St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amos Moffett

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE: Years 71 | Months — | Days — | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lapwai Idaho

PARENTS
10 NAME OF FATHER: Ke-kee-mas Allen
11 BIRTHPLACE OF FATHER (city or town) (State or country): Kamiah Idaho
12 MAIDEN NAME OF MOTHER: Tom-lah
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lapwai Idaho

14 Informant: George Gaignard M.D.
(Address) Culdesac, Ida

15 Filed Oct. 20, 1929 L. Maxwell REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from ----, 19--, to ----, 19--, that I last saw h---- alive on ----, 19--, and that death occurred, on the date stated above, at ---- m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

---- (duration) ---- yrs. ---- mos. ---- ds.

CONTRIBUTORY (SECONDARY) ----
---- (duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ---- Date of ----
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Dr. George Gaignard M. D.
10/10/, 19 (Address) Culdesac, Ida

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Mission Cemetery
DATE OF BURIAL: Oct. 4, 1929

20 UNDERTAKER: Brower-Wann Co
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

RECEIVED JAN 16 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

69297

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Lapwai or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Albert

(a) Residence. No. Lapwai St., Ward. B1
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amelia Albert

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE: Years 71 | Months — | Days — | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Amelia Albert-Wife
(Address) Lapwai, Ida

15 Filed Nov. 12, 1929 L. Maxwell
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12" 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1928 to Nov. 12, 1929, that I last saw him alive on Nov. 12, 1929, and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) 1 yrs. mos. 12 ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) George Gaignard, M. D.
12/6, 1929 (Address) Culdesac, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Sweetwater Cemetery
DATE OF BURIAL: Nov. 15 1929

20 UNDERTAKER: Brower-Wann Co.
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JAN 16 1930

69298

1 PLACE OF DEATH

County Nez Perce State Idaho Registered No.

Township or Village Juliaetta and Vicinity or

City No. , St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Daniel

(a) Residence. No. Juliaetta, Ida. St., Ward. 90

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: 4/4 Nez Perce Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mollie Seven

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lapwai Idaho

PARENTS

10 NAME OF FATHER: Pops-te-mo-ne-kin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Whitebird Idaho

12 MAIDEN NAME OF MOTHER: Lydia Daniel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lapwai Idaho

14 Informant: Corbett B. Lawyer-Clerk

(Address) Lapwai, Ida.

15 Filed Nov. 18, 1929 F. W. Maxwell REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 15" 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1929, to Nov. 12, 1929, that I last saw him alive on Nov. 12, 1929, and that death occurred, on the date stated above, at ---- m.

The CAUSE OF DEATH* was as follows:

Mytral Regurgitation

(duration) yrs. 4 mos. 9 ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Gaignard M. D.

12/6, 1929 (Address) Culdesac, Ida

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Potlatch Cemetery

DATE OF BURIAL: Nov. 16, 1929

20 UNDERTAKER: Brower-Wann Co.

ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JAN 16 1930

1 PLACE OF DEATH

County Nez Perce State Idaho Registered No. 69299

Township ..... or Village Lapwai or

City ..... No. ....., ... St., ... Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Teslawood 31

(a) Residence. No. Lapwai, Ida St., ... Ward. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: 4/4 Nez Perce Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ah-to-kah

6 DATE OF BIRTH (month, day, and year): 185[illegible]

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
78	–	–	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Invalid

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Joseph McCormack Farmer
(Address) Lapwai, Ida

15 Filed Nov. 20, 1929 L. A. Maxwell
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 19" 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18", 1929, to Nov. 18", 1929, that I last saw him alive on Nov. 18", 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) George Gaignard, M. D.

12/5, 1929 (Address) Culdesac, Ida

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Lapwai Cemetery

DATE OF BURIAL: Nov. 20" 1929

20 UNDERTAKER: Brower-Wann Co.

ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

RECEIVED JAN 16 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

60398

1 PLACE OF DEATH
County Idaho State Idaho Registered No.
Township or Village Kooskia or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Martha Yellow Bear 100a

(a) Residence. No. Kooskia St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	4/4 Nez Perce Indian	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Yellow Bear

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	82	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kooskia
(State or country) Idaho

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) "
(State or country) "
12 MAIDEN NAME OF MOTHER "
13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) "

14 Informant Corbett B. Lawyer-Clerk
(Address) Lapwai, Idaho

15 Filed Oct. 9, 1929 H. Maxwell REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8" 1929

17 I HEREBY CERTIFY, That I attended deceased from October 4, 1929, to October 8", 1929, that I last saw her alive on Oct. 7", 1929, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. M. Verberkmoes, M. D.
10/2/1930 (Address) Kooskia, Ida

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Kooskia cemetery	Oct. 10, 1929
20 UNDERTAKER	ADDRESS
G. W. Irenary	Kooskia

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

RECEIVED JAN 16 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

69301

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Lapwai or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John Lowry

(a) Residence. No. Lapwai St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tahmahwenunmy

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE: Years 67 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lapwai
(State or country) Idaho

PARENTS
10 NAME OF FATHER How listah now nin
11 BIRTHPLACE OF FATHER (city or town) Lapwai
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Neome Lowry
13 BIRTHPLACE OF MOTHER (city or town) Lapwai
(State or country) Idaho

14 Informant Corbett B. Lawyer Clerk
(Address) Lapwai, Ida.

15 Filed Nov. 8, 1929 L. A. Maxwell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8" 1929

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
No doctor in attendance
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Spalding Cemetery
DATE OF BURIAL: Nov. 9 1929

20 UNDERTAKER: Brower-Wamr Co
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

11—3184 GOVERNMENT PRINTING OFFICE

RECEIVED JAN 1[illegible]

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

69302

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Webb or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert Francis Johnson

(a) Residence. No. Webb, Ida St., Ward. 140
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE 3/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 30, 1929

7 AGE Years Months 2 Days 9 If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lewiston
(State or country) Idaho

PARENTS
10 NAME OF FATHER Frank Johnson
11 BIRTHPLACE OF FATHER (city or town) Kamiah
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Pauline Hill
13 BIRTHPLACE OF MOTHER (city or town) Webb
(State or country) Idaho

14 Informant George Gaignard, M.D.
(Address) Culdesac, Ida.

15 Filed Oct. 10, 1929 [illegible] Maxwell
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1929

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Hemophilia
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Dr. George Gaignard, M. D.
10/10/, 1929 (Address) Culdesac, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Webb Cemetery
DATE OF BURIAL Oct. 12 1929

20 UNDERTAKER Brower-Wann Co
ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

FORM V. S. [illegible] 15M. 1-19

RECEIVED JAN 25 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69344

Local Registrar's No. 148

1. PLACE OF DEATH

County of Shoshone

City of Burke

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mack Cyr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1861 (Year)

7. AGE: 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Maine

10. NAME OF Father: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hecla Mining Co
(Address) Burke Ida

15. Filed Dec 28 1929 F. L. Quigley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 24 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..., that I last saw him alive on Dec 24 19..., and that death occurred on the date stated above, at 9:05 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis Chr

F B Pulmonary all lobes (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) F B Pulmonary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr Mowery M. D.

12/26 1929 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida

DATE OF BURIAL: 12-28 1929

20. UNDERTAKER: Lance G. Warstell

ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JAN 25 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69345

Local Registrar's No. 147

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Obrad Ronovich.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH ..... (Month) ..... (Day) ..... 1 (Year)

7. AGE: about 35 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner.

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF Father

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) None

(Address) .....

15. Filed Dec 27 1929 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

11a

16. DATE OF DEATH 12 (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 19..., to Dec 23 1929, that I last saw him alive on Dec 22 1929, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) Alcoholism

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

12/23 1929 (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida.

DATE OF BURIAL: 12-27 1929

20. UNDERTAKER: Bruce T. Warstell

ADDRESS: Wallace Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69346

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 7011
(No. Wallace, Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 146

2. FULL NAME Dorothy W. McDonall

(a) Residence. No. Street, Idaho St. Sunset, Idaho 10
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 29 - 1927

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	2	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace, Idaho.

PARENTS

10. NAME OF FATHER L. M. McDonall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Esther Hackman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nyska.

14. Informant L. M. McDonall
(Address) Wallace, Idaho.

15. Filed Dec 24, 1929. J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 21 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1929, to Dec 21, 1929
that I last saw her alive on Dec 21, 1929
and that death occurred, on the date stated above, at 7:00 P m.
The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec 21 1929
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Arthur C Jordan M. D.
Dec 23, 1929 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho.	Dec 24 1929
20. Undertaker J. A. Beaver Ward Und. Co.	Address Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69347

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 10 11
Local Registrar's No. 145
(No. Providence Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number)

74a

2. FULL NAME Lola G. Deichert.
(a) Residence. No. Gatlese Mont. St. Gatlese, Mont.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of N. J. Deichert.

6. DATE OF BIRTH (month, day and year) March 21-1881

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	8	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spokane Wash.

PARENTS

10. NAME OF FATHER Thomas Rose
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Julia Peter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa.

14. Informant N. J. Deichert
(Address) Gatlese, Mont.

15. Filed Dec 22, 1929 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1929, to Dec 19 1929, that I last saw h.e alive on Dec 19 1929, and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. few mos. days

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. few mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Dr. Geo. Avery, M. D.
12-20, 1929 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wash.	Dec 22 1929
20. Undertaker J. A. Bever Ward Und. Co.	Address Wallace, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69348

PLACE OF DEATH
County of Shoshone
City of Wallace Murray
Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 144
(No. 186)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George E. Reese
(a) Residence. No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 30 - 1873.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	11	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Millman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Cedar Creek Mng. Co.

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mr Wm Becker
(Address) Wallace Idaho.

15. Filed Dec 17, 1929 E. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h[illegible] alive on ..., 19...
and that death occurred, on the date stated above, at 1.00 A m.
The CAUSE OF DEATH* was as follows: Accidentally by [illegible] fall in Cedar Creek Mine [illegible] Idaho
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? None
(Signed) [illegible] Mallory Coroner
12/14/, 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Storm Lake, Iowa. Date of Burial Shipped Dec 1929
20. Undertaker J. A. Bwer Address
Ward Und Co. Wallace, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69349

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011

Local Registrar's No. 143

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Julius J. Guedelhofer
(a) Residence. No. Wallace Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) 1859 - Dec 11
7. AGE, Years 71 Months – Days – If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mine
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Germany.

PARENTS
10. NAME OF FATHER John Guedelhoefer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Magdalin Schmidt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Otto C. Guedelhoefer
(Address) Indianapolis Ind

15. Filed Dec 16, 1929 E. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/10/29, 19..., to 12/11, 1929
that I last saw him alive on 12/11/29, 19...
and that death occurred, on the date stated above, at 11 45 a m.
The CAUSE OF DEATH* was as follows:
Chr. Int. Nephritis
(duration) 4 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) James R Dean, M. D.
12/16/29, 19... (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Indianapolis Ind — Date of Burial 12/16/29
20. Undertaker R. L. Stout — Address Kellogg Ida

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JAN 25 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone

City of Burke

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

State File No. 69350

Local Registrar's No. 142

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gwennelyn Jean Sharksman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: October (Month) 10 (Day) 1929 (Year)

7. AGE: ..... Yrs. 1 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Wallace Ida

10. NAME OF Father: T. J. Sharksman

11. BIRTHPLACE OF FATHER (State or Country): Paris Texas

12. MAIDEN NAME OF MOTHER: Julia Cunn

13. BIRTHPLACE OF MOTHER (State or Country): Denver Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. J. Sharksman
(Address) Burke Ida

15. Filed Dec 9 1929 F. L. Quigley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

162

16. DATE OF DEATH: Dec (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...., that I last saw her alive on ..... 19...., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Myasthenia Several Days

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Spinal Bifida Congenital

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Mowery M. D.

12/9 1929 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida

DATE OF BURIAL: 12-9- 1929

20. UNDERTAKER: Bruce S. Horstell

ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 25 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 69351

Registered No. 141

Registration District No. 70

Primary Registration District No. 1011

(No. Shoshone Co. Infirmary St.)

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vencal Shuta

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH. 8 (Month) — 28 (Day) 1883 (Year)

7. AGE 46 Yrs. 3 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Austria

10. NAME OF FATHER Ventra Shuta

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. M. Rogers
(Address) Shoshone County Infirmary

15. Filed Dec 12 1929 F. R. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 31 (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/30/29 1929, to 12/6 1929, that I last saw him alive on 12/6 1929, and that death occured on the date stated above, at 2:45 P. M.

The CAUSE OF DEATH* was as follows:

Pulm. tuberculosis

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary) Silicosis 2 yrs. Valv. Heart years.

(Duration yrs. mos. ds.

12/9 19 (Signed) James R Bean M. D.

(Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 8 days. In the State 25 yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kellogg Idaho | DATE OF BURIAL Dec. 12 1929

20. UNDERTAKER H. L. Stout | ADDRESS Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

RECEIVED JAN 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69352

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 140

88B

2. FULL NAME Kate Fouche Boyd.
(a) Residence. No. Pearl St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Widowed.
6. DATE OF BIRTH (month, day and year) April 25-1848
7. AGE 81 Years, Months 8, Days 11, If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Muscatine Iowa.

PARENTS
10. NAME OF FATHER James B. Fouche
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Mary Luffingwell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Conn.

14. Informant John C. Boyd.
(Address) Wallace, Idaho.
15. Filed Dec 10, 1929. F. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 6 (Day) 1929 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 1928, to Dec 6, 1929
that I last saw her alive on Dec 6, 1929
and that death occurred, on the date stated above, at 7 a m.
The CAUSE OF DEATH* was as follows:
Myocarditis Chr
(duration) Several yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) Several yrs. mos. ds.
18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Dr. Norwood, M. D.
1/7, 1929 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace Idaho
Date of Burial Dec 10 1929
20. Undertaker Jackson Ward and Co.
Address Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69353
Local Registrar's No. 139

1. PLACE OF DEATH — JAN 25 1930

County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John F. Lynn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH: Oct (Month) 28 (Day) 1866 (Year)

7. AGE: 53 Yrs. 1 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF Father: Henry F. Lynn

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Catherine McLaughlin

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Providence Hospital
(Address) Wallace Idaho

15. Filed Dec 4 1929 J. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

74a

16. DATE OF DEATH: 12/2/29 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1929 to Dec 2 1929, that I last saw him alive on Dec 1 1929, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. L. Quigley M. D.
12/4 1929 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho
DATE OF BURIAL: 12/4/29 19

20. UNDERTAKER: Wardell Co
ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 25 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 70

County of Shoshone — Primary Registration District No. 1011 — File No. 69354

City of Wallace — (No.) Shoshone County Infirmary — Registered No. 138

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fitzgerald Patrick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. 10 (Month) 20 (Day) 1860 (Year)

7. AGE 68 Yrs. 1 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Chicago Ill

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. H. Rogers

(Address) Shoshone County Infirmary

15. Filed Dec 14 1929 — J. L. Quigley, Local Registrar

MEDICAL CERTIFICATE OF DEATH

100a

16. DATE OF DEATH 11 (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-23- 1929, to 11-25- 1929, that I last saw him alive on 11-25- 1929, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

5

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Silicosis - Arteriosclerosis

(Duration ..... Yrs. ..... mos. ..... ds.

11 (Signed) James R. Bean M. D.

19 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Ida — DATE OF BURIAL: Dec 14 1929

20. UNDERTAKER: R. L. Stout — ADDRESS: Kellogg Ida

SVMS - YORK CO., PTRS. & BDRS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 25 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70

Primary Registration District No. [illegible]

File No. 69355

Registered No. 137

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Shoshone County Infirmary

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kaske Otto

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 10 (Day) 1841 (Year)

7. AGE: 68 Yrs. 5 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Trapper

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Otto Kaske

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Gretchen Kaske

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. W. Pegues

(Address) Shoshone County Infirmary

15. Filed Dec 14 1929

Local Registrar

MEDICAL CERTIFICATE OF DEATH

74a

16. DATE OF DEATH: Nov (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-1-1928, to 11-23-1929, that I last saw h[illegible] alive on 11-23-1929, and that death occured on the date stated above, at 10 1/2 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary) Arteriosclerosis

(Duration) 4 yrs. mos. ds.

(Signed) James R Brown M. D.

11/24 1929 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg Ida

DATE OF BURIAL: Dec 14 1929

20. UNDERTAKER: R. L. Stout

ADDRESS: Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69362

PLACE OF DEATH
County of Shoshone
City of Enaville

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 2
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME X John Shirley Crowe
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) X Oct. 16, 1891

7. AGE: Years 38, Months 2, Days 6. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Driving truck on highway
(b) General nature of industry, business, or establishment in which employed (or employer): Co. Highway
(c) Name of employer: W. P. Swinerton

9. BIRTHPLACE (city or town) (State or country): Vandergrift, Penn. U.S.

PARENTS
10. NAME OF FATHER: John Crowe
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn. U.S.
12. MAIDEN NAME OF MOTHER: Frances Faust
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn. U.S.

14. Informant X Mrs. Selma Crowe
(Address) Enaville, Ida.

15. Filed Jan. 30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1929, to Dec 23, 1929, that I last saw him alive on Dec 22, 1929, and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Cerebral hemorrhage.
..... (duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Symptoms
(Signed) W C Lindsay, M. D.
1/14, 1930 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg Idaho
Date of Burial: 12/28, 1929

20. Undertaker: M. C. Thornhill
Address: Kellogg, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC[illegible] FEB 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

7

DO NOT WRITE IN THIS SPACE
State File No. 69377

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 57
Primary Registration District No. 1010
Local Registrar's No. 28

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Kissiah E Riggs
(a) Residence: No. New Meadows St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7
4. COLOR OR RACE Wh
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of James Riggs

6. DATE OF BIRTH (month, day and year) Feb 18-1843

7. AGE 86 Years | Months 10 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS

10. NAME OF FATHER Thos Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Crain
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant W. T. Riggs
(Address) New Meadows

15. Filed Dec 31, 1929. W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5, 1929, to Dec 29, 1929
that I last saw her alive on Dec 29, 1929
and that death occurred, on the date stated above, at 12:30 a.m.
The CAUSE OF DEATH* was as follows:

Abdominal Carcinoma
Pancreas.
..... (duration) 8 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Phys Ex & X Ray.
(Signed) Ernesto Finney M. D.
Jan 1, 1930 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hillcrest Cemetery | Date of Burial: 12-31-1929
20. Undertaker: L. C. Northam | Address: Weiser Ida

FEB 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69378

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 7
Primary Registration District No. 1010
(No. .....)
Local Registrar's No. 26

(If death occurred in a hospital or institution, give its name instead of street and number.)

48a

2. FULL NAME Charleth V. Campbell

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 21- 1911

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
18	6	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER James M Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Lena Ottmann
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant J M Campbell
(Address) Weiser Idaho

15. Filed Dec 17, 1929. M. K. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 11th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4th, 1929, to Dec 11th, 1929
that I last saw her alive on Dec 10th, 1929
and that death occurred, on the date stated above, at 1 A. m.
The CAUSE OF DEATH* was as follows:

Rheumatic Fever
Endocarditis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Embolism
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) E C Hiatt M.D.
Dec 17th, 1929 (Address) Weiser, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	12-14-1929
20. Undertaker L. C. Markham	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69379

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 87
Primary Registration District No. 1010
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 25

47

2. FULL NAME Mary F. Galloway

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Thos C. Galloway

6. DATE OF BIRTH (month, day and year) Apr 1st—1846

7. AGE 83 Years Months 8 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS

10. NAME OF FATHER A. W. Flournoy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Ann E. Holland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant Flournoy Galloway
(Address) Weiser Ida

15. Filed Dec 16th, 1929 W. K. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 2nd (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1925, to Dec 2, 1929
that I last saw her alive on Dec 2, 1929
and that death occurred, on the date stated above, at 11:30 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma Breast.
..... (duration) 4 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of Aug 10. 25
Was there an autopsy? no.
What test confirmed diagnosis? Microscopic
(Signed) Ernest O Finney, M. D.
12/16, 1929 (Address) Weiser Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hill crest Cemetery — Date of Burial Dec 5th 1929

20. Undertaker L. C. Northam — Address Weiser Ida

RECEIVED FEB 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69380

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 87
Primary Registration District No. 1010
(No. Little Flower Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

145 B

2. FULL NAME Sylvia Catherine Coffman.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Everette H. Coffman.

6. DATE OF BIRTH (month, day and year) Oct. 26 1907

7. AGE Years 21 Months 11. Days 5. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10. NAME OF FATHER Neal McMillan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Mary E. Roller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant E H Coffman
(Address) Weiser Idaho

15. Filed Oct 7th, 1929 M. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1929, to Oct 5, 1929
that I last saw her alive on Oct. 5, 1929
and that death occurred, on the date stated above, at 10:30 a m.
The CAUSE OF DEATH* was as follows: Instrument delivery followed by shock full term pregnancy
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Difficult labor
..... (duration) ..... yrs. ..... mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Oct 4th
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. Schmidt M. D.
Oct. 6, 1929 (Address) Weiser I.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Gilt Cord Cemetery — Date of Burial Oct. 7th 1929

20. Undertaker Le Roy Northam — Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69381

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 57
Primary Registration District No. 1910
Local Registrar's No. 24

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

169

2. FULL NAME Eliza Bowers Brodshaw

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of R. M. Brodshaw

6. DATE OF BIRTH (month, day and year) Oct 1 - 1862

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	2	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER John Moyers.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Eliza B Satchell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant R. M. Brodshaw
(Address) Weiser Ida

15. Filed Nov 2nd, 1929 M. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 1st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Suicide by Drowning in bath Tub.
Several attempts made before (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No Inquest
What test confirmed diagnosis?
(Signed) L. C. Northam Coroner
Dec 4th, 1929 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	12-4 1929
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current Complete December 1929

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69454

PLACE OF DEATH

County of Ft. Hall Reservation, Idaho

City of

CERTIFICATE OF DEATH

Registration District No. I2I

Primary Registration District No. 2I94

Local Registrar's No. 16

(No. ------)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME Janette Browning.

(a) Residence. No. ------ St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Browning

6. DATE OF BIRTH (month, day and year) --- I885----

7. AGE Years 44 Months -- Days --- If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Inkom, Idaho

PARENTS

10. NAME OF FATHER Bill Jackson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nevada

12. MAIDEN NAME OF MOTHER Yah-gwan-ah

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Inkom, Idaho

14. Informant Willie Warren,
(Address) Ft. Hall, Idaho

15. Filed Feb. 26, 19 30 Mrs Walter E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 29. I929 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. IO, 19 I7, to Dec. 29, I929, 19

that I last saw her alive on Dec. 28, I929, 19

and that death occurred, on the date stated above, at 7: A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) I2 yrs. 9 mos. I(ds.

CONTRIBUTORY (Secondary) Apoplexy-cerebral

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? ----

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? ---

(Signed) Mary R. Wheeler, M. D.

, 19 (Address) ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Portneuf Cemetery, ft. Hall Reservation, Jan. 2, 30 Date of Burial 19

20. Undertaker Shoemaker & Beasley, Pocatello. Address

Current

Complete December 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED MAR 5 - 1930

DO NOT WRITE IN THIS SPACE
State File No. 69455

PLACE OF DEATH

Ft. Hall Reservation, CERTIFICATE OF DEATH

County of Idaho.
City of
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 15
(No. ----)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74 a

2. FULL NAME Harry Preacher.

(a) Residence. No. ****** St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Shoshone Ind. 4/4	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alice Preacher

6. DATE OF BIRTH (month, day and year) ---- 1842----

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ruby Valley, Nevada

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Tom Preacher,
(Address) Ft. Hall, Idaho

15. Filed Feb. 26, 1930 Walter E. Pahs
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 25, 1929
(Month) (Day) (Year)
No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw h.... alive on ....., 19....
and that death occurred, on the date stated above, at 6:P m.
The CAUSE OF DEATH* was as follows:

Apoplexy- cerebral.

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) -----

.....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? ---
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Harry R. Wheeler, M. D.
....., 19.... (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Portneuf Cemetery Ft. Hall Reservation,	Dec. 28. 1929
20. Undertaker	Address
Brown, Eldredge,	Blackfoot, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Current

Complete December 1929

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69456

County of Ft. Hall Reservation, Idaho

Registration District No. 121

City of

Primary Registration District No. 2194

Local Registrar's No. 14

(No. ---------)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1

2. FULL NAME Woodrow Honena

(a) Residence. No. ------- St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Ind. 4/4	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6. DATE OF BIRTH (month, day and year) May 8, 1928

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	7	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft. Hall Reservation

PARENTS

10. NAME OF FATHER Samuel Honena

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemhi Reservation

12. MAIDEN NAME OF MOTHER Laura Tendoy

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lemhi Reservation

14. Informant Samuel Honena

(Address) Ft. Hall, Idaho

15. Filed Feb. 26, 1930 Walter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 14, 1929 (Month) (Day) (Year)

No Doctor attending.

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at 6:P m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia- bronchial

(duration) ... yrs. 3 mos. ... ds.

18. Where was disease contracted if not at place of death? ----

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry L. Wheeler M. D.

..., 19... (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Presbyterian Cemetery, Ft. Hall Reservation, Dec	I6, 29 19

20. Undertaker	Address
Agency Carpenter, Ft. Hall, Ida.	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 - 1930 Current

Complete December 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69457

PLACE OF DEATH
County of Ft.Hall Reservation, Idaho. CERTIFICATE OF DEATH
City of
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 13
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jefferson Tonitz.

(a) Residence. No. ------- St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Shoshone Ind. 4/4	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Mink.

6. DATE OF BIRTH (month, day and year) --- 1880

7. AGE	Years	Months	Days	If LESS than 1 day,
	49	---	----	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer ---

9. BIRTHPLACE (city or town) (State or country) Ft.Hall Reservation

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Poo-ee-weep.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ft.Hall Reservation

14. Informant Poorah Wheeler,
(Address) Ft.Hall, Idaho

15. Filed Feb.26, 1930 Walter E. Petrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 6, ~~1930~~ 1929 3
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 31, 1929, to Dec.6, 1929, that I last saw him alive on Dec. 4, 1929, and that death occurred, on the date stated above, at 8.P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) ---
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ---
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs

(Signed) Henry P. Wheeler M. D.
, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Portneuf Cemetery, Ft.Hall Reservation , Ida	12- 10-29 19

20. Undertaker H.L.Mc.Han, Pocatello, Address Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69498

PLACE OF DEATH
County of Boundary
City of Porthill

Registration District No. 79
Primary Registration District No. 2127

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joe Aikens

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer U.S. Forest Service

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant U.S. Forest Service
(Address) Employment Camp Bonners Ferry, Ida.

15. Filed Sept. 2, 1929 E.E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 3' P m.

The CAUSE OF DEATH* was as follows:
Fractured Skull Vertex
Struck by falling tree
(Died 2 hours after injury)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination of body

(Signed) Chas Bonnell M. D.
Sept. 1, 1929. (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Olwein, Iowa.	

20. Undertaker Address
H.K. Crouch, Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69499

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 126

2. FULL NAME George Herbert Altham
(a) Residence. No. ..... St. Hillcrest, Alberta
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug. 4 - 1877
7. AGE: Years 52, Months, Days 23; If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Master Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Hillcrest Collieries
9. BIRTHPLACE (city or town) (State or country): England

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Cecil Altham
(Address) McCloud, Alberta

15. Filed Aug. 28, 1929 S. E. Fry, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1929, to Aug. 27, 1929
that I last saw him alive on Aug. 27, 1929
and that death occurred, on the date stated above, at 11:30 P.m.
The CAUSE OF DEATH* was as follows:
Peritonitis
(duration) yrs. mos. 15 ds.
CONTRIBUTORY (Secondary): Infected hemorrhoids.
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? Spokane, Wn
Did an operation precede death? Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) S. E. Fry, M. D.
Aug. 28, 1929 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: New Westminster B.C. Date of Burial 19
20. Undertaker: H. R. Crouch, Bonners Ferry. Address

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69500

PLACE OF DEATH

County of Boundary Registration District No. 79
City of Bonners Ferry Primary Registration District No. 2156 Local Registrar's No.
(No.) Bonners Ferry Hospital. 65-A
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME R. O. Carmichael.

(a) Residence. No. Nolan, Mont St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 3 - 1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	1	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Harness Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant R. O. Carmichael
(Address) Nolan, Mont

15. Filed Aug 9, 1929 E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1929, to Aug 8, 1929
that I last saw h-- alive on Aug 8, 1929
and that death occurred, on the date stated above, at 6:35 P. m.
The CAUSE OF DEATH* was as follows:

Splenomyelogenous Leukemia ?
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Noxon Montana
Did an operation precede death? No Date of
Was there an autopsy? No Blood Examination
What test confirmed diagnosis?
(Signed) Earl Bonnell, M. D.
Aug 8, 1929 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Id	Aug 13 1929

20. Undertaker H. P. Crouch, Bonners Ferry. Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69501

PLACE OF DEATH
County of Boundary
City of Meadow Creek

Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME Charles L. Bartlett

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Bartlett

6. DATE OF BIRTH (month, day and year): Sept. 20 - 1860

7. AGE: Years 48, Months 9, Days 10. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Melrose, Illinois

PARENTS

10. NAME OF FATHER: E. Bartlett

11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York

12. MAIDEN NAME OF MOTHER: Edwards

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: Don Bartlett
(Address): Meadow Creek Ida

15. Filed: Aug. 10, 1929 E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Sudden Death
Myocardial Insufficiency
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History
(Signed) R. M. Bowell Coroner
July 30, 1929 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida
Date of Burial: Aug 10 1929

20. Undertaker: H. R. Crouch, Bonners Ferry
Address

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69502

PLACE OF DEATH
County of Boundary
City of Bonners Ferry
Registration District No. 79
Primary Registration District No. 2154
Local Registrar's No.
(No.) 48B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James G. Foley.

(a) Residence: No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Effie Foley.

6. DATE OF BIRTH (month, day and year) Nov. 27-1873

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	10	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Timber Cruiser & Merchant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada.

PARENTS

10. NAME OF FATHER Thomas Foley

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Hanna Stevens.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant Mrs. Effie Foley.
(Address) Bonners Ferry Idaho

15. Filed Sept. 30, 1929. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1928, to Sept. 29, 1929, that I last saw h[illegible] alive on Sept. 29, 1929, and that death occurred, on the date stated above, at 12:55 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration -
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Atrial insufficiency.
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Physical Examination

(Signed) E. E. Fry M. D.
Sept. 30, 1929. (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry	Oct. 1 1929
20. Undertaker	Address
H. R. Crouch,	Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69503

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156

Local Registrar's No. 204

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Barr,

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April, 1850

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	5		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ontario Canada

PARENTS

10. NAME OF FATHER: George Barr
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant H.W. Barr
(Address) Wasa, B.C. Canada.

15. Filed 9/16/29, 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 16 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Chronic Myocardial Degeneration
(Sudden death)
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History

(Signed) Chas Bowdell M. D.
Sept 16, 19 29 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	Sept. 19 1929

20. Undertaker: H.R. Crouch, Address: Bonners Ferry, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 22504

Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No.

48P

PLACE OF DEATH
County of Boundary
City of Naples.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Valentine Ott

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Jan. 14 - 1894

7. AGE — Years: 35 — Months: 8 — Days: 11 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Invalid.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Virginia City, Minn.

PARENTS

10. NAME OF FATHER: Walter Ott
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Clarks Mills, Wis.
12. MAIDEN NAME OF MOTHER: Tillie Gary (Guay)
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mich.

14. Informant: Walter Ott
(Address): Naples, Idaho

15. Filed Sept. 25, 1929 — E E Fry — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 25th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary): Arthritis deformans.
(duration) 25 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis?

(Signed) E E Fry, M. D.
Sept. 25, 1929. (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida. — Date of Burial: Sept. 26 1929

20. Undertaker: A R. Crouch — Address: Bonners Ferry Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69505

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

Registration District No. 79

Primary Registration District No. 2156

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME Walter William Peters,

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb. 26, 1929

7. AGE: Years | Months: 6 | Days: 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bonners Ferry, Idaho

PARENTS

10. NAME OF FATHER: Richard Peters

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Bertha Lenarz

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): North Dakota

14. Informant: Richard Peters
(Address) Bonners Ferry, Idaho.

15. Filed 9/24, 1929. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 23, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 23, 1929 that I last saw him alive on Sept 23, 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Spasmophilia

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. M. Bowell, M. D.

Sept 24, 1929 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida. | Date of Burial: Sept. 25, 19

20. Undertaker: H.R. Crouch, Bonners Ferry, Ida. | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69506

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

1886

2. FULL NAME Thomas J. Buck

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed or divorced
HUSBAND of (or) WIFE of Lorena Buck

6. DATE OF BIRTH (month, day and year) Aug. 9, 1896.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	1		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Truck Driver & Auto Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Service Garage

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS

10. NAME OF FATHER Charles L. Buck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Cornelia Ballard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Mrs. Lorena Buck,
(Address) Bonners Ferry, Ida.

15. Filed 9/8/ 29. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 8, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Accidental death -
Automobile crash -
Fracture of skull - (Basilar)
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) R.M. Boswell Coroner M. D.
Sept 8, 1929 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	Sept. 11, 1929

20. Undertaker — Address
H.R. Crouch, Bonners Ferry.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69507

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

Registration District No. 77

Primary Registration District No. 2156

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

119

2. FULL NAME Florence Adeline Peters

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 5 - 1925

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
3	11	2.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bonners Ferry Ida

PARENTS

10. NAME OF FATHER Richard Peters

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Bertha Lenarg

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Dakota

14. Informant Richard Peters

(Address) Bonners Ferry Ida

15. Filed 9/8/ 1929 E. E. Fox Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 7, (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30, 1929, to Sept 7, 1929

that I last saw her alive on Sept 7, 1929

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Ileocolitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) R. W. Bowell, M. D.

Sept 8, 1929 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida. Date of Burial: Sept. 8 1929

20. Undertaker: H. R. Crouch, Bonners Ferry. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69508

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. Bonners Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

161a

2. FULL NAME Baby Johnson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Sing a

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 4 - 1929.

7. AGE Years Months Days If LESS than 1 day, 3½ hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bonners Ferry, Ida

PARENTS
10. NAME OF FATHER Arvid L. Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn.
12. MAIDEN NAME OF MOTHER Leda Slate
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash

14. Informant A. L. Johnson
(Address) Bonners Ferry, Ida

15. Filed 9/4/, 1929. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on Sept 4, 1929
and that death occurred, on the date stated above, at 11:30 A.m.
The CAUSE OF DEATH* was as follows: Premature Birth (7 mo)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Placental Infarct

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Eric Bowell, M. D.
Sept 4, 1929 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bonners Ferry, Ida. Date of Burial Sept. 4 1929

20. Undertaker H. R. Crouch, Bonners Ferry. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69509

PLACE OF DEATH
County of Boundary
City of Moravia

Registration District No. 79
Primary Registration District No. 3156.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME Edward James Morkeberg
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Oct. 1-1929.
7. AGE Years Months Days 12 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Moravia, Ida.

PARENTS
10. NAME OF FATHER Hans Henry Morkeberg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Skovturup, Denmark.
12. MAIDEN NAME OF MOTHER Letta Thomas.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kirby Mo.

14. Informant Hans Henry Morkeberg
(Address) Moravia, Ida.
15. Filed 10/13, 1929. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 12 - 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on Oct. 1st, 1929.
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Marasmus.
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) (Diarrhoea) - Ileocolitis
(duration) yrs. mos. 6 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis?
(Signed) E. E. Fry, M. D.
10/13/, 1929. (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Moravia, Ida. Date of Burial Oct. 14 1929
20. Undertaker Jas. S. Morkeberg Address Moravia, Ida.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69510

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

101a

2. FULL NAME Phillip Barney
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 24-1861

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
67	11	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Quebec Canada

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Frank Barney
(Address) Minneapolis, Minn.

15. Filed Dec. 14, 1929 E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Dec 13, 1929
that I last saw him alive on Dec 12, 1929
and that death occurred, on the date stated above, at 12:05 A m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) Kim Bowell, M. D.
Dec 14, 1929 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Minneapolis, Minn. Date of Burial 19

20. Undertaker: H. R. Crouch, Bonners Ferry Ida. Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69511

PLACE OF DEATH

County of Boundary

City of Naples

Registration District No. 79

Primary Registration District No. 2156

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

151

2. FULL NAME Asa J. Cossairt

(a) Residence. No. St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 5, 1904

7. AGE: Years 25, Months 3, Days 29. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Montana

PARENTS

10. NAME OF FATHER: Henry Cossairt

11. BIRTHPLACE OF FATHER (city or town) (State or Country): ILlinois

12. MAIDEN NAME OF MOTHER: Addie Long

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn.

14. Informant: Mrs. Addie Cossairt

(Address) Naples, Idaho

15. Filed Dec. 5, 1929. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 4, 1929. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1929, to Oct. 4th, 1929.

that I last saw him alive on Dec. 1st, 1929

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows: Gangrene of the lung.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Gunshot wound.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Naples, Ida.

Did an operation precede death? Yes. Date of Oct. 5-1929

Was there an autopsy? No.

What test confirmed diagnosis? Spontane.

(Signed) E. E. Fry, M. D.

Dec. 5, 1929. (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: McArthur, Idaho. Date of Burial: Dec. 6 1929.

20. Undertaker: H.R. Crouch, Bonners Ferry, Ida. Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69512

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

Registration District No. 79

Primary Registration District No. 7156

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Sherman.

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married.

5a. If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Annie Sherman.

6. DATE OF BIRTH (month, day and year) Oct. 18-1874.

7. AGE	Years	Months	Days	If LESS than 1 day,
	55	1	15	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minden City, Mich.

PARENTS

10. NAME OF FATHER Henry Sherman.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) London, Canada

14. Informant Mrs. Annie Sherman,
(Address) Bonners Ferry, Ida.

15. Filed Dec. 4, 1929. D. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 3rd. 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Degeneration (Sudden death)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no. What test confirmed diagnosis? History of Case.

(Signed) D. E. Fry, M. D.

Dec. 4, 1929, (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Spokane, Wash.	

20. Undertaker	Address
A. R. Enoch	Bonners Ferry, Ida.

RECEIVED FEB 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69592

PLACE OF DEATH

County of Kootenai
City of Spirit Lake

Registration District No. 45
Primary Registration District No.
Local Registrar's No. 11

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1st e

2. FULL NAME Francis Lea Snook

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 21, 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Spokane
(State or country) Wash.

PARENTS

10. NAME OF FATHER Melvin C. Snook

11. BIRTHPLACE OF FATHER (city or town) Wilson Creek
(State or Country) Washington

12. MAIDEN NAME OF MOTHER Agnes Redfox

13. BIRTHPLACE OF MOTHER (city or town) Cottage Grove
(State or Country) Oregon

14. Informant Melvin C. Snook
(Address) Spirit Lake Idaho

15. Filed Dec 26, 1929 A C Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 25 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1929, to Dec 25, 1929
that I last saw her alive on Dec 25, 1929
and that death occurred, on the date stated above, at 7:15 P. m.
The CAUSE OF DEATH* was as follows:

Spina bifida (congenital)

(duration) yrs. 11 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Congenital
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A C Spooner, M. D.
12-26, 1929 (Address) Spirit Lake Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood Cemetery - Spirit Lake	12-27 1929
20. Undertaker	Address
Cassedy Funeral Home	Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69593

Registration District No. 45
Primary Registration District No.
Local Registrar's No. 10

PLACE OF DEATH
County of Kootenai
City of Spirit Lake
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

112

2. FULL NAME Marvin Floyd Dawson

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	Wh.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 2, 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Spirit Lake
(State or country) Idaho

PARENTS

10. NAME OF FATHER Orvin Floyd Dawson
11. BIRTHPLACE OF FATHER (city or town) Red Lodge
(State or Country) Mont
12. MAIDEN NAME OF MOTHER Lucile Bernice Fry
13. BIRTHPLACE OF MOTHER (city or town) Doniphan
(State or Country) Nebraska

14. Informant Orvin Dawson
(Address) Spirit Lake Ida

15. Filed Dec 11, 1929. A. C. Spooner
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2, 1929, to Dec 10, 1929
that I last saw him alive on Dec 10, 1929
and that death occurred, on the date stated above, at 12-30 a.m.
The CAUSE OF DEATH* was as follows:
Ac. gastro-enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. C. Spooner, M. D.
, 19 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 03594

Registration District No. 45
Primary Registration District No.
Local Registrar's No. 9

PLACE OF DEATH
County of Kootenai
City of Spirit Lake
(No. 440)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Roland Joel Richardson

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Jan. 19-1920
7. AGE: Years 9 | Months 10 | Days 23 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School Boy.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Elk. Wash.

PARENTS
10. NAME OF FATHER: Joel Richardson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indianapolis Ind.
12. MAIDEN NAME OF MOTHER: Josephine Green
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Threeriversport Pa.

14. Informant: Mrs Josephine Richardson
(Address): Spirit Lake Idd.
15. Filed Dec 2, 1929 A C Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 2. 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Dec 1, 1929
that I last saw h[illegible] alive on Dec 1, 1929
and that death occurred, on the date stated above, at 3.10 P m.
The CAUSE OF DEATH* was as follows:
Ac. endocarditis (rheumatic)
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A C Spooner, M. D.
Dec 2, 1929 (Address) Spirit Lake Idd

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Greenwood Cemetery Spirit Lake. | Date of Burial: 12-4 1929
20. Undertaker: Cassedy Funeral Home | Address: Rathdrum

RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69618

PLACE OF DEATH
County of Nez Perce
City of Cameron

Registration District No. 63
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101B

2. FULL NAME Mrs. Sophie Olddag
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Olddag

6. DATE OF BIRTH (month, day and year) Feb. 17 - 1849

7. AGE Years 80 Months 10 Days 9 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dometz, Germany

PARENTS
10. NAME OF FATHER Jo Battles
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Louis Olddag
(Address) Cameron, Idaho

15. Filed Dec 26, 1929 B. G. Nestor Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 26 (Day) 1929. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1929, to Dec. 26, 1929.
that I last saw her alive on Dec. 15, 1929.
and that death occurred, on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:
Terminal pneumonia
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage hemiplegia
(duration) yrs. 2 mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. H. Field M. D.
Dec. 26, 1929. (Address) Kendrick, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Cameron Ida — Date of Burial Dec 28 1929

20. Undertaker John J Pickerd — Address Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69619

Registration District No. 63
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Lolah
City of Cameron
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

80

2. FULL NAME Ferdinand Fredrick Silflow

(a) Residence. No. Cameron, Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Silflow

6. DATE OF BIRTH (month, day and year) Jan 25th 1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	10	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER John Silflow
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Wilma Lohman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs Fred Silflow Sr.
(Address) Cameron, Ida.

15. Filed Dec 20, 1929 B. F. Neebit Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Dec 20, 1929, that I last saw him alive on Dec. 17, 1929, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:
Pernicious Anemia

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings and laboratory findings

(Signed) E. H. Field M. D.
Dec. 21, 1929 (Address) Kendrick, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cameron	Dec 22 1929
20. Undertaker	Address
J. F. Pickrell	Troy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 62620

Registration District No. 63
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Latah
City of Leland
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

10-B

2. FULL NAME Clinton Clifford Powell

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 14-1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Leland, Ida.

PARENTS

10. NAME OF FATHER Clifford P. Powell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweet Wash.
12. MAIDEN NAME OF MOTHER Effie L. Gallaher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spokane, Wash.

14. Informant Clifford P. Powell
(Address) Leland, Ida.

15. Filed Dec 20, 1929 B.P. Merkt, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1929, to Dec. 20, 1929
that I last saw him alive on Dec. 14, 1929
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:
Unknown
9 hrs.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Report
(Signed) E. T. Tull M. D.
Dec. 20, 1929, (Address) Kendrick Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Leland	Dec 21 1929
20. Undertaker	Address
Tull	—

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69631

PLACE OF DEATH
County of Lemhi
City of Salmon
Registration District No. 4
Primary Registration District No. 216
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Shoup Woods

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles A Woods

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	1	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Abram Shoup
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bedford Co Penn.
12. MAIDEN NAME OF MOTHER Rebecca Van Deagor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Huntington County Penn.

14. Informant Mrs. Faith Shoup Robinson
(Address) San Altos, California

15. Filed Feb 11, 1930. Clio Ballamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 29th. 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-9, 1929, to Oct-29, 1929
that I last saw h[illegible] alive on Oct-29, 1929
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Cancer bowels
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F S Wright, M. D.
Dec 30, 1929 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	10-30th 1929
20. Undertaker	Address
McCracken	Salmon Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69632

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

48B

2. FULL NAME John Gordon
(a) Residence No. Salmon Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE Years: about 74 Months: Days: If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: County Farm
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): American

PARENTS
10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: Wm C Dockler
(Address) Salmon Idaho

15. Filed Feb 11, 1930 Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 1st 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Dec 1st, 1929
that I last saw him alive on Dec 1, 1929
and that death occurred, on the date stated above, at 9-P m.
The CAUSE OF DEATH* was as follows:
Myocarditis
Several months (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
Dec 19, 1929 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery
Date of Burial: 12-2" 1929
20. Undertaker: Wm C Dockler
Address: Salmon

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. 6-25 M. 1-D. RECD. MAR 8 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69642
Local Registrar's No. 9

1. PLACE OF DEATH
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby T. Joe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Brown
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH: Dec. 4 (Month) (Day) 1930 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Rexburg Idaho

10. NAME OF Father: T. Joe

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: ~~Unknown~~ Yoshiko Baba

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. Joe
(Address) .....

15. Filed 2/19 1930 J. W. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH 162

16. DATE OF DEATH: Dec (Month) 6 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1929 to Dec 6 1929, that I last saw him alive on Dec 6 1929, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Patulous foramen ovale

..... (Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

2/19 1930 (Signed) Lorin A. Rich M. D.
(Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg Cemetary
DATE OF BURIAL: 12/7 1929

20. UNDERTAKER: A. B. Edwards
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner,** (b) **Cotton Mill;** (a) **Salesman,** (b) **Grocery;** (a) **Foreman,** (b) **Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of .....(name origin; "Cancer' is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,** etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH MAR 3 1930

County of Washington

City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH.

Registration District No.

Primary Registration District No.

(No. , St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 69708

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cora Bell Boils Greene

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Maud

6. DATE OF BIRTH. Sept (Month) 1 (Day) 1893 (Year)

7. AGE 36 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Silas Boiles

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) × Arvald Greene

(Address) Cambridge Ida

15. Filed 2-28-30 191 R W Whiteman Jr Local Registrar

MEDICAL CERTIFICATE OF DEATH

95

16. DATE OF DEATH December (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/13/29 191 , to 12/20/29 191 , that I last saw her alive on 12/20/29 191 , and that death occured on the date stated above, at 7:00 A M.

The CAUSE OF DEATH* was as follows:

Internal hemorrhage

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Castro-intestinal ulcer

(Duration) ? yrs. mos. ds.

(Signed) G. F. Hurst H 6 M. D.

19 (Address) Cambridge, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salubria

DATE OF BURIAL: 12-21 1929

20. UNDERTAKER: J A Hudelson

ADDRESS: Cambridge

SVMS - YORK CO., PTRS. & BDRS. 24654

of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 8 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

69793

Registered No.

1 PLACE OF DEATH
County Kootenai. State Idaho.
Township 47. or Village Worley. or
City ____ No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

10178

2 FULL NAME John Baptist Vallee.
(a) Residence. No. ____ St., ____ Ward. Yes.
(Usual place of abode) Worley. Idaho. (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. Infant. ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.
4 COLOR OR RACE: Spokane - Indian.
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) About Sep 17th/29.

7 AGE — Years: ____ Months: ____ Days: 30. If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: ____
(b) General nature of industry, business, or establishment in which employed (or employer): ____
(c) Name of employer: ____

9 BIRTHPLACE (city or town) ____
(State or country)

PARENTS
10 NAME OF FATHER Dave Vallee.
11 BIRTHPLACE OF FATHER (city or town) Worley. Idaho.
(State or country)
12 MAIDEN NAME OF MOTHER Plicity Wildshoe.
13 BIRTHPLACE OF MOTHER (city or town) Montana.
(State or country)

14 Informant Annie Vallee
(Address) Worley. Idaho.

15 Filed March 7, 1930 John Poot REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17th/29. 19

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to Oct 17th/29 19____, that I last saw h____ Oct 17th/29. on ____, 19____, and that death occurred, on the date stated above, at 11. A m.

The CAUSE OF DEATH* was as follows:

Pneumonia.

____ (duration) ____ yrs. ____ mos. 8 ds.

CONTRIBUTORY (SECONDARY) T. B.

____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Don't know.

Did an operation precede death? No. Date of ____

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) ____, M. D.

____, 19 (Address) Worley. Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: De Smet. Idaho.
DATE OF BURIAL: Oct 20/ 19 29

20 UNDERTAKER: C. L. Schuberus
ADDRESS: Tekoa Wash.

RECEIVED APR 7 1930

S. F. No. 825—1921. Approved as to Form by Dept. of Efficiency. 4832.

Idaho

~~Washington~~ State Board of Health

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bonner

City or Town of Carrywood

Registration Dist. No. 78 No. Death occured at the Suing's farm house.
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Record No. 69819

Registered No. 32

2. FULL NAME Lora P. Bell

(a) Residence No. _____ St.; (Usual place of abode)

(b) If non-resident, give city or town, and state _____

(c) How long in Registration Dist. 23 yrs. ____ mos. ____ ds.; how long in U. S. if of foreign birth ____ yrs. ____ mos. ____ ds.

74a

Personal and Statistical Particulars

3. Sex: female
4. Color or Race: white
5. Single, Married, Widowed or Divorced (Write the word): Married

5. (a) If married, widowed or divorced:
Husband of _____
or
Wife of W. P. Bell

6. Date of birth: Sept. (Month) 21 (Day) 1864 (Year)

7. Age: 65 yrs. 1 mos. 11 ds. If less than one day hrs. ____ or min. ____

8. Occupation of deceased:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. Birthplace (City or town): Oshkosh
(State or country): Wisconsin

PARENTS

10. Name of Father: Alonzo Leach
11. Birthplace of Father (City or town) (State or Country): Vermont
12. Maiden name of Mother _____
13. Birthplace of Mother (City or town) (State or Country) _____

14. Informant: Mr. W. P. Bell
Address: Carrywood, Idaho

15. Filed: Dec. 3, 1929 Viola Allen Deputy Registrar.

Medical Certificate of Death

16. Date of death: December 1, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1929, to Dec. 1, 1929 that I last saw her alive on _____, 192__ and that death occurred on the date stated above, at 4:30 P m.
(State the disease causing death, or in deaths from violent causes, state: (1) Means and nature of injury; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL).
The CAUSE OF DEATH was as follows:

(Primary) Cerebral Hemorrhage. Was called when illness began but deceased had expired before my arrival. (Duration) ____ yrs. ____ mos. 10 minutes ds.

CONTRIBUTORY (Secondary) General Atheroma. (Duration) about 3 yrs. ____ mos. ____ ds.

18. Where was disease contracted If not at the place of death? _____
(a) Did an operation precede death? No Date of _____
(b) Was there an autopsy? No
(c) What test confirmed diagnosis? _____

(Signed) Frank Henry M. D.
12/1, 1929 Address Rathdrum, Idaho

19. Place of Burial, Cremation or Removal: Greenwood
Date of Burial: Dec., 4, 1929

20. Undertaker: Turnbull - Merager
Address: Spokane, Wash.

I HEREBY CERTIFY, upon honor, That I have made the effort but was unable to secure answers to questions _____ (Insert numbers of unanswered questions)

O. Merager (Signature of Undertaker)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

V. S. No. 1—100M—10-31-27.

RECEIVED MAR 20 1930

PLACE OF DEATH

County of Jefferson

City of Roberts

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 9 8

Primary Registration District No. 2176

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69022

Local Registrar's No. .....

44

2. FULL NAME Hans Martin Larson

(a) Residence. No. ..... Roberts, Idaho St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Christina Elizabeth Larson

6. DATE OF BIRTH (month, day and year) October 2 1853

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	2	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mail Carier (Retired 10 yrs)

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Martin Larson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Hannah Larson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs Lillie Neyman

(Address) Roberts, Idaho

15. Filed DEC 31 1929 O K Larson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 11, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2, 1929, to Dec 11, 1929

that I last saw her alive on Dec 11 1929

and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

O.K.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility - Fracture of femur

(duration) yrs. mos.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Carl D. Jones M.D.

....., 19..... (Address) Roberts [redacted]

*State the DISEASE CAUSING DEATH, or in deaths from [redacted] CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Independence	Dec. 14 1929
20. Undertaker Jack A. Stout	Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

w parent.

RECEIVED MAR 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 98

DO NOT WRITE IN THIS SPACE
State File No. 69923

PLACE OF DEATH

County of Jefferson
City of Rigby
Registration District No. 98
Primary Registration District No. 312
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

306

2. **FULL NAME** Baby Youngstrom.

(a) Residence. No. Rigby. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 12/9/29

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER Enoch Youngstrom.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Utah.

12 MAIDEN NAME OF MOTHER Jane Johnston

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Arizona.

14 Informant Enoch Youngstrom
(Address) Rigby. Idaho.

15 Filed DEC 31 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 9 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on Dec. 9, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Lung Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. R. Nutzegley, M. D.
12/10, 1929 (Address) Rigby

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: annis Idaho. Date of Burial: 12-10 1929

20. Undertaker: A B Edwardsell Address: Rigby

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

F

DO NOT WRITE IN THIS SPACE
State File No. 69959

PLACE OF DEATH

County of Minidoka

City of Rupert

CERTIFICATE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

(No. .....)

Local Registrar's No. 9

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

101a

2. FULL NAME Patrick P. O'Donnell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug 15 — 1873

7 AGE: Years 56 | Months 0 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick O'Donnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ferrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary J. O'Donnell
(Address) Rupert Idaho

15 Filed 4-3, 1930 E H Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 30 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1929, to Aug 28, 1929, that I last saw him alive on Aug 28, 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar Lower lobes, bilateral

(1) ..... (duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) (2) Arteriosclerosis

Apoplexy (duration) (1) about 5 yrs. ..... mos. (2) 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) E H Elmore M. D.

4-3, 1930 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cem Catholic Part | Date of Burial: Aug 2 1929

20. Undertaker: W. A. Goodman | Address: Rupert Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69981

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 57

90

2. FULL NAME Ada Belle Spohr
(a) Residence. No. Paona Colo St. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wilson Spohr

6. DATE OF BIRTH (month, day and year) July 14-1880

7. AGE Years 49 Months 5 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ,
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa Nebr

PARENTS
10. NAME OF FATHER John Shank
11. BIRTHPLACE OF FATHER (city or town) (State or Country) W. Va
12. MAIDEN NAME OF MOTHER Sadie Cook
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mary McClure
(Address) Fruitland, Ida.

15. Filed Dec 31, 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 13 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1929, to Dec. 13, 1929
that I last saw her alive on Dec. 13, 1929
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease.
unknown (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Colorado.
Did an operation precede death? no. Date of .....
Was there an autopsy? no.
What test confirmed diagnosis? none
(Signed) Merrill R. Fox M. D.
Dec. 16, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal New Plymouth Ida — Date of Burial Dec 17 1929

20. Undertaker J. H. Adair — Address Paterson Farm Co Payette Ida.

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69982

PLACE OF DEATH

County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 30

129

2. FULL NAME Mrs Martie C. Frakes.

(a) Residence. No. 535 N. 10th St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

3a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas J. Frakes.

6. DATE OF BIRTH (month, day and year) April 7 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	8	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER Butler.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown.
12. MAIDEN NAME OF MOTHER unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown.

14. Informant Wylie T. Frakes.
(Address) Ontario, Ore.

15. Filed Dec 31, 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1929, to Dec 29, 1929, that I last saw h alive on Dec 29, 1929 and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings only

(Signed) C. A. Palmer, M. D.
Dec 31, 1929 (Address) Ontario Ore

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette Idaho.	Dec 31, 1929
20. Undertaker	Address
Glenn C. Landon.	Payette Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 1 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69983

Local Registrar's No. 49

164

PLACE OF DEATH
County of Bayette
City of Bayette

Registration District No. 4
Primary Registration District No. 1008
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nettie Madden

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 13 1854

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. H.

PARENTS

10. NAME OF FATHER Chas D Cate
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. H.
12. MAIDEN NAME OF MOTHER V
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. H.

14. Informant J N Cadan
(Address) Bayette Ida

15. Filed Dec 15 1929 J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1929 to Dec 13 1929
that I last saw her alive on Dec 13 1929
and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:
Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) J C Woodward, M. D.
Dec 15, 1929 (Address) Bayette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bayette Ida	Dec 15 1929
20. Undertaker	Address
D Madsen Peterson Furn Co	Bayette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69984

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 48

(No. 2) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas Edson Scott

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) May 16 1880

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49	6	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) ✓
(State or country)

PARENTS

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (city or town) ✓
(State or Country)

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (city or town) ✓
(State or Country)

14. Informant J. A. Cadair
(Address) Payette Ida.

15. Filed Dec 10 29 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH About Nov 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:
Found dead Weakened
Condition due to bad Heart
& Lung trouble complicated
by exposure
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) J. A. Cadair Coroner, M. D.
Dec 6, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette Ida	Dec 6 1929
20. Undertaker J. A. Cadair	Address
Peterson Furn Co	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69985

PLACE OF DEATH
County of Payette
City of Nan Fruitland

Registration District No. 4
Primary Registration District No. 1008.
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 47.

129

2. FULL NAME May G. Wildeson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Harry J Wildeson

6. DATE OF BIRTH (month, day and year) Apr 10 1885

7. AGE Years 44 Months 7 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Calif

PARENTS
10. NAME OF FATHER Geo H Wetherw
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓ ✓
12. MAIDEN NAME OF MOTHER Susan E — —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Calif

14. Informant Harry Wildeson
(Address) Fruitland

15. Filed Dec 7, 1929 J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 6th (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929, to Dec 6th, 1929
that I last saw her alive on Dec 6, 1929
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis
Myocarditis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Double lobar pneumonia
..... (duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? no Date of ✓
Was there an autopsy? no.
What test confirmed diagnosis? Clinical
(Signed) W J Weese, M. D.
Dec 6, 1929 (Address) Ontario, Ore.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. ~~Place of Burial~~, Cremation, ~~or Removal~~ Portland Ore. Date of Burial Dec 9 1929

20. Undertaker J. Hedan Address Paterson Furn Co Payette Ida

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6998C

PLACE OF DEATH
County of Payette
City of Fruitland Registration District No. 4
Primary Registration District No. 1008.
Local Registrar's No. 46

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Samuel Phillipsi

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Esther L. Phillipsi

6. DATE OF BIRTH (month, day and year) Oct 9-1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	1	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Randolph, Wisconsin

PARENTS

10. NAME OF FATHER Joseph Phillipsi
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant E. L. Phillips
(Address) Emmett Idaho

15. Filed Dec 2, 1929 J. R. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 30 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 13 1928 19 , to Nov 29, 1929
that I last saw h~~im~~ alive on Nov 29, 1929
and that death occurred, on the date stated above, at 3 p m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J R Woodward M. D.
Dec 1, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wood River, Neb	Dec 6 1929
20. Undertaker	Address
C W Buckmann	Emmett Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1930

PLACE OF DEATH

County of Payette

City of Payette

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 4

Primary Registration District No. 1008

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69988

Local Registrar's No. 44

2. FULL NAME Addah La Rue Gorton

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 29, 1910

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	7	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Payette Ida

PARENTS

10. NAME OF FATHER John B. Gorton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich

12. MAIDEN NAME OF MOTHER Addah M Arner

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Mrs Nora Loveland
(Address) Payette Idaho

15. Filed Nov 30, 1929. J G Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18, 1929, to Nov 29, 1929
that I last saw h— alive on Nov 28, 1929
and that death occurred, on the date stated above, at about 6c m.

The CAUSE OF DEATH* was as follows:

Pulmonary
Probably embolus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic arthritis rheumatism

(duration) yrs. mos. 12 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J G Woodward, M. D.

Nov 30, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette Idaho	Dec 1 1929

20. Undertaker	Address
Glenn C Landon	Payette Ida

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69989

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 43

PLACE OF DEATH
County of Payette
City of Payette
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Josephine M Randall

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Geo B Randall

6. DATE OF BIRTH (month, day and year) Feb 28 1881

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	8	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wash.

PARENTS
10. NAME OF FATHER Nephi Owens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.
12. MAIDEN NAME OF MOTHER Elizabeth Campbell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant D E Cedar
(Address) Payette Ida

15. Filed Nov. 16, 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1929, to Nov. 16, 1929, that I last saw her alive on Nov. 16, 1929 and that death occurred, on the date stated above, at 6:05 A. m.

The CAUSE OF DEATH* was as follows:
Cancer of breast with generalized metastases. 2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of Mar. 1929
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Merrill A. [illegible], M. D.
Nov. 16, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bruneau Ida	11/18 1929

20. Undertaker D. E. Cedar Address Peterson Furn Co Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69990

PLACE OF DEATH
County of Payette
City of Payette
Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 42
(No.) 90
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Moore

(a) Residence. No. 536 7th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jennie Moore

6. DATE OF BIRTH (month, day and year) 1851 - Sept - 4th

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	2	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) not employed
(c) Name of employer

9. BIRTHPLACE (city or town) Ontario
(State or country) Canada

PARENTS

10. NAME OF FATHER Fredrick Moore
11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country) ✓
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) ✓
(State or Country)

14. Informant Jennie Moore
(Address) 536 7th Payette

15. Filed Nov 16, 1929. J.C. Woodward
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1929, to Nov. 14, 1929
that I last saw h[er] alive on Nov. 14, 1929
and that death occurred, on the date stated above, at 4 30 A. m.
The CAUSE OF DEATH* was as follows:

Cardiovascular-renal disease.
indefinite. (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? None.

(Signed) Merrill R. Fox, M. D.
Nov. 15, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette Idaho	11-16 1929
20. Undertaker	Address
Glenn C Landon	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69991

PLACE OF DEATH
County of Payette
City of Payette
Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 41
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Mary Ann McEvoy

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 25, 1850

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	8	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Ontario, Canada
(State or country)

PARENTS

10. NAME OF FATHER John Cady
11. BIRTHPLACE OF FATHER (city or town) Ireland
(State or Country)
12. MAIDEN NAME OF MOTHER Ann
13. BIRTHPLACE OF MOTHER (city or town) Ireland
(State or Country)

14. Informant Dan McLean
(Address) Payette Idaho

15. Filed Nov. 8, 1929 J. C. Woodward
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 8 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1929, (to) Nov. 8, 1929, that I last saw h[illegible] alive on Nov. 8, 1929 and that death occurred, on the date stated above, at 1:10 P. m.

The CAUSE OF DEATH* was as follows:

Cardiovascular-renal disease

indefinite (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Merrill R. Fox, M. D.
Nov 8, 1929 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sault Ste Marie, Mich	Nov 9 1929
20. Undertaker	Address
Glenn & Landon	Payette Ida

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69992

PLACE OF DEATH

County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008.

Local Registrar's No. 40

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

98 B

2. FULL NAME John W. Fincher

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 27 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	10	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansaw

PARENTS

10. NAME OF FATHER John W Fincher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknowed
12. MAIDEN NAME OF MOTHER unknowed
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknowed

14. Informant Mrs. J.E. Lake
(Address) Payette Idaho

15. Filed Nov 2, 1929 J.B. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 1 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1929, to Nov. 1, 1929, that I last saw him alive on Nov. 1, 1929, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chr.

indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? None

(Signed) Merrill L. Fox M. D.
Nov. 2, 1929 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette Idaho	Nov 3 1929
20. Undertaker	Address
Glenn C Landon	Payette Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PRINT PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69993

PLACE OF DEATH

County of Payette
City of Payette

CERTIFICATE OF DEATH

Registration District No. 4
Primary Registration District No. 1008
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 39

2. FULL NAME Elvira J. Frazier

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of S R Frazier

6 DATE OF BIRTH (month, day and year) May 18 1856

7 AGE: Years 73 | Months 5 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10 NAME OF FATHER Henry J Stewart
11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.
12 MAIDEN NAME OF MOTHER Martha A Knight
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind.

14 Informant I. H. Adair (Family Record)
(Address) Payette

15 Filed Oct 30, 1929 J. B. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 27 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1929, to Oct 27, 1929, that I last saw her alive on Oct 27, 1929, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:
Myocarditis
indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? None
(Signed) Merrill J. Fox M. D.
Oct 28, 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: New Plymouth
Date of Burial: Oct 30 1929

20. Undertaker: I H Adair
Address: Payette Ida
Peterson Furn Co

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

59934

County of Canyon

City of Payette — Registration District No. 4 — Primary Registration District No. 1008 — Local Registrar's No. 38.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Abraham C Chadwick

(a) Residence. No. St. 7th a

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anna C Chadwick

6. DATE OF BIRTH (month, day and year) March 30 1844

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	6	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS

10. NAME OF FATHER Abraham C Chadwick

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Burton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Anna Chadwick

(Address) Payette Idaho

15. Filed Oct 28, 1929. J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 28 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~, 19, to ~, 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 5:15 p.m.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy — No physician in attendance Dead when I arrived —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J R Woodward M. D.

10/29, 1929 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise Idaho	Oct 31 1929

20. Undertaker	Address
Glenn C Landon	Payette Ida

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69996

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008.

Local Registrar's No. 35

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

201

2. FULL NAME Mrs Julia Noodle

(a) Residence. No. Nisth St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): widowed.
5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Jacob Nodle
6. DATE OF BIRTH (month, day and year): Jan 11 - 1851
7. AGE: Years 78 | Months 7 | Days 29 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS
10. NAME OF FATHER: Richard Crashaw.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ky.
12. MAIDEN NAME OF MOTHER: Mary Ann Rothchild.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ky.

14. Informant: Mrs C M. Bowman.
(Address) Payette Ida.

15. Filed Sept. 12 1929. J. C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 8 1929 to Sept. 10 1929
that I last saw h alive on Sept 10 1929
and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows: Fracture of Right Femur
Slipped on Kitchen floor
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? X Ray

(Signed) J. C Woodward M. D.
Sept 12 1929 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette. Ida.	Sept 12 1929
20. Undertaker	Address
Glenn C Sanders	Payette Ida.

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

June 27, 1930

RECEIVED JUN 30 [illegible]

Dr. J.C. Woodward
Payette

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

- -

In reference to the death certificate of:

Mrs. Julia Noodle who died at Payette, Idaho on Sept. 10, 1929
Cause of death give as: "Fracture of Right Femur"

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO PLEASE STATE WHETHER IT OCCURRED ON HIGHWAY OR IN CITY

PLEASE ANSWER BELOW:

THIS WAS NOT AN AUTOMOBILE ACCIDENT. MRS NODLE, AN AGED WOMAN CAUGHT HER FOOT ON AN INEQUALITY OF THE KITCHEN FLOOR, SLIPPED AND SUFFERED A FRACTURE OF THE FEMUR. SHE DIED FROM SHOCK IN ABOUT $8 HOURS

J.C.WOODWARD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1930

PLACE OF DEATH

County of Payette

City of Payette

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69997

Registration District No. 4

Primary Registration District No. 1008

Local Registrar's No. 34

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William L. Gulick 90

(a) Residence. No. 806 - 3rd Ave. South St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 27-1850

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
77	—	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Zachariah Gulick.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Pinkerton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio.

14. Informant: J. R. Gulick
(Address): Grants Pass Ore

15. Filed Sept 5, 1929. J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1916, 19..., to 9/30, 1929

that I last saw him alive on 9/30, 1929

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows: Mitral regurgitation

(duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J R Woodward M. D.

Sept 4, 1929 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cambridge Id. Date of Burial: Sept 5 1929

20. Undertaker: Glenn C Sanders Address: Payette Ida.

RECEIVED MAR 1 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69998

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008.

Local Registrar's No. 33

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Talbert B. Biggerstaff.

(a) Residence. No. 151 - 7th Ave. W. St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 2 1851

7. AGE — Years: 78 | Months: 2 | Days: 29 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stock Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Arkansas.

PARENTS

10. NAME OF FATHER: Wesley Biggerstaff
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown
12. MAIDEN NAME OF MOTHER: Mary E. Parker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown.

14. Informant: C. V. Laughlin
(Address) Payette Ida

15. Filed Sept 2, 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 31 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929, to Aug 31, 1929
that I last saw h[illegible] alive on Aug 31, 1929
and that death occurred, on the date stated above, at 9:30 P. m.
The CAUSE OF DEATH* was as follows:

Cardiovascular hypertensive disease

indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? None
(Signed) Merrill R. Cox, M. D.
Sept 1, 1929 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Council Place — Date of Burial: Sept 2 1929

20. Undertaker: Glenn C. Sanders — Address: Payette, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70114

PLACE OF DEATH Bannock
County of ~~Bannock~~
City of ~~Soda Springs~~ Idaho Grace

Registration District No. 84
Primary Registration District No. 2161
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 176

31

2. FULL NAME William H. Larkin
(a) Residence. No. Grace St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Dora Larkin

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 73 | Months 1 | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): Cattleman
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Salt Lake City, Utah

PARENTS
10. NAME OF FATHER: Wm J. Larkin
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Caroline Hansen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Cora L. Thatcher
(Address) 486 E 1st Logan Ut.

15. Filed Apr 18, 1930. Mrs. G. L. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 5, 1929
that I last saw him alive on April 1, 1929
and that death occurred, on the date stated above, at 9:15 P m.
The CAUSE OF DEATH* was as follows:
Tuberculosis Pulmonary
(duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) 0
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? 0 Date of .....
Was there an autopsy? 0
What test confirmed diagnosis? Physical Ex.
(Signed) Eric Kuckly, M. D.
4-6-, 1929 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Thatcher, Id. Cemetery | Date of Burial: Apr 8 1929

20. Undertaker: Larkin & Sons | Address: Ogden, Ut.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70225

PLACE OF DEATH

County of Fremont

City of Heman

Registration District No. 99

Primary Registration District No. 2177

Local Registrar's No. 322

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth McFarland

(a) Residence. No. St. Anthony Ida Route 3 St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~[illegible]~~ of (or) WIFE of Archie C. McFarland

6. DATE OF BIRTH (month, day and year) Feb. 3 - 1877

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	10	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Odgen Utah

PARENTS

10. NAME OF FATHER Alfred Stanford

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Jenkins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) South Wales

14. Informant A. C. McFarland
(Address) Route 3 - St. Anthony Idaho

15. Filed Dec. 17, 1929 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1929, to Dec 16, 1929

that I last saw her alive on Dec 16 1929

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis,
(Anasarca)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Sepsis following trimming of a Corous on Rt ~~[illegible]~~ toe.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. B. Rigby, M. D.

Dec 18, 1929 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation, or~~ Removal: Odgen, Utah

Date of Burial: Dec. 22 1929

20. Undertaker: W. M. Hansen

Address: St. Anthony Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70238

PLACE OF DEATH
County of Lincoln
City of Wendell

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 162

2. FULL NAME Anna Willard

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 1 - 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wendell Ida

PARENTS

10. NAME OF FATHER Lawrence D Willard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Mary M Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant Lawrence D Willard
(Address)

15. Filed Dec 4, 1929 E L Swanton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Dec 3, 1929
that I last saw her alive on Dec 2 1929
and that death occurred, on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E L Swanton, M. D.
Dec 4, 1929 (Address) Wendell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wendell Ida	Dec 5 1929
20. Undertaker	Address

RECEIVED MAY 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70239

PLACE OF DEATH
County of Gooding Registration District No. 22
City of Wendell Primary Registration District No. 2018
(No. _____)
Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Eliza Mc Anulty

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of W. A. Mc Anulty

6 DATE OF BIRTH (month, day and year)

7 AGE Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
69	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston Mass

PARENTS
10 NAME OF FATHER Theodore Jordyn
11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant W. A. Mc Anulty
(Address) Glenns Ferry Idaho

15 Filed Mch 1, 1929 E. L. Simonton Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb (Month) 28 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1929, to Feb 28, 1929, that I last saw her alive on Feb 28, 1929, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH was as follows: Acute Pancreatitis

(duration) 1 yrs. _____ mos. 1 ds.

CONTRIBUTORY (Secondary) Post Operative

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? Yes Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Diabetic blood

(Signed) E. L. Simonton, M. D.

3-1, 1929, (Address) Wendell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Glenns Ferry	3-2 1929
20. Undertaker A. E. Jamieson	Address Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70240

Local Registrar's No.

PLACE OF DEATH
County of Gooding
City of Wendell
Registration District No. 12
Primary Registration District No. 2018
(No. 167 (If death occurred in a hospital or institution, give its name instead of street and number.))

2. FULL NAME Robert Everett Rutherford

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49		19 -	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) -
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wendell Ida

PARENTS
10 NAME OF FATHER David H. Rutherford
11 BIRTHPLACE OF FATHER (city or town) (State or country) Colorado
12 MAIDEN NAME OF MOTHER Ethel May Prichard
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Oregon

14 Informant David H. Rutherford
(Address) Wendell Ida

15 Filed 2-19, 1929 E. L. Dinsmoor
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb (Month) 19 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1929 to Feb 19 1929
that I last saw him alive on Feb 18 1929
and that death occurred, on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(duration) yrs. mos. ds.
CONTRIBUTORY -
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? -
(Signed) E. L. Dinsmoor, M. D.
2-19, 1929 (Address) Wendell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Wendell Ida — Date of Burial: 2-20 1929

20. Undertaker — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70243

PLACE OF DEATH

County of Gooding

City of [redacted]g

Registration District No.

Primary Registration District No.

Local Registrar's No.

Wendell St Valentine [redacted] Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Wm C. Custer

(a) Residence. No. Shoshone Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Regina Custer

6. DATE OF BIRTH (month, day and year): Apr 28 1856

7. AGE: 73 Years | Months: — | Days: 5 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Proprietor Meat Mkt

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Westfall Germany

PARENTS

10. NAME OF FATHER: Wm Custer

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: W W Custer
(Address) Shoshone, Ida.

15. Filed 4-30, 1930 C. L. Simonton
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1929, to May 3, 1929 that I last saw him alive on May 3, 1929 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Cardio Vascular
Renal Disease

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. E. Zeller M. D.

5/21, 1929 (Address) Jerome, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAY 2 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Gooding — Registration District No. 22

City of Wendell — Primary Registration District No. 2018 — File No. 70244

(No. ....., ... St.) — Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Nephi Condie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. August (Month) 3 (Day) 1883 (Year)

7. AGE: 46 Yrs. 8 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Croydon Utah

10. NAME OF FATHER: Thomas Condie

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah Swan

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) J. W. Condie

15. Filed Dec 9 1929 — E. L. Sinnett, Local Registrar

MEDICAL CERTIFICATE OF DEATH

204

16. DATE OF DEATH: Dec (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
This man was found dead 48 hours after supposed death. Coroner pronounced death from ~~Disease~~ Contributory Cause
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. L. Sinnett M. D.
12-9 1929 (Address) Wendell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Croydon Utah — DATE OF BURIAL ..... 191...

20. UNDERTAKER: Daniel L. Hennefer — ADDRESS Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & BOKS. 24853

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH MAY 2 1930

County of Gooding

City of Wendell

Registration District No.

Primary Registration District No.

(No. , St.)

File No. 70247

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Ann Lumb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow (Write the word.)

6. DATE OF BIRTH May (Month) 14 (Day) 1849 (Year)

7. AGE 80 Yrs. 4 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Derbyshire England

10. NAME OF FATHER John Spooner

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Vickers

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas H Lumb

(Address) Shoshone

15. Filed Oct 11 1929 E L Simonton Local Registrar

MEDICAL CERTIFICATE OF DEATH

100a

16. DATE OF DEATH Oct (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11 1929 to Oct 11 1929 that I last saw her alive on Oct 11 1929 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. L. Simonton M.D.

11-11 1929 (Address) Wendell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Shoshone Ida

DATE OF BURIAL 11-13 1929.

20. UNDERTAKER C. E. Hecock

ADDRESS Shoshone Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. [illegible] M. 1-19 RECEIVED MAY 2 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ..... , ... St.)

File No. 70218
Registered No. .....

1. PLACE OF DEATH
County of Gooding
City of Wendell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Married

6. DATE OF BIRTH: March (Month) 25 (Day) 1878 (Year)

7. AGE: 50 Yrs. 11 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Weston Idaho

10. NAME OF FATHER: Swin Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Ann Elizabeth Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Oct 7 1929 E L Dimmitt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 4 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1928 to Oct 4 1929
that I last saw h.. alive on Sept 18 1929
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows: Sarcoma of the thigh

(Duration) 3 Yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Dimmitt M.D.
10-7 1929 (Address) Wendell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wendell Ida	Oct 7 1929

20. UNDERTAKER: Simpson Furniture Co. ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. REC'D MAY 2 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 2018
File No. 70249
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Wendell (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha May Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: June (Month) 2 (Day) 1894 (Year)

7. AGE: 35 Yrs. 2 Mos. 23 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: Charles F. Nelson

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Fredericka Lunberg

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles F. Nelson
(Address) Wendell Ida.

15. Filed Aug 29 1929 E L Simonton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 5108

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 25 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1929 to Aug 25 1929 that I last saw h[illegible] alive on Aug 25 1929 and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows: Stroke of lightening
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E. L. Simonton M. D.
8-29 1929 (Address) Wendell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wendell Ida. DATE OF BURIAL: 8-28 1929
20. UNDERTAKER: George Smith ADDRESS: Wendell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-26 M. 1-16-29 RECEIVED MAY 2 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 70250

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 22-

Primary Registration District No. 2018

County of Gooding

City of Wendell (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Vincent Long

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 3 (Day) 1914 (Year)

7. AGE: 15 Yrs. 5 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wendell Idaho

10. NAME OF FATHER: John C Long

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Dorothy Archambo

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John C Long

(Address) Wendell Idaho

15. Filed Dec 10 1929 E L Dinsmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1929 (Year) 10 A

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1929, to Dec 10 1929, that I last saw him alive on Dec 10 1929, and that death occured on the date stated above, at 3 45 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E L Dinsmore M. D.

12-11 1929 (Address) Wendell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida — DATE OF BURIAL: 12-17 1929

20. UNDERTAKER: Thompson Furniture Co — ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOOKS. 24653

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71,621

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015

Local Registrar's No. 16

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

124

2. FULL NAME William Harve Harris

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	55			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER W. D. Harris
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Cora M. Harris
(Address) Rupert Idaho

15. Filed 6-10-, 1930 E. V. Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 15-, 1929, to Aug. 1, 1929
that I last saw h~~im~~ alive on Aug. 1, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Nephritis (Chronic)
(duration) 2? yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J B Kenagy, M. D.
5-13-, 1930 (Address) Rupert

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rupert Cemetery	Aug 7 1929
20. Undertaker	Address
W. A. Goodman	Rupert, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

PLACE OF DEATH

County of Minidoka

City of Rupert

Registration District No. 19

Primary Registration District No. 2015

Local Registrar's No. 21

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Lester B Deno

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 1 1926

7. AGE: Years 4 ~~4~~ | Months 1 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: Lester E Deno

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Bertha May

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Lester E Deno
(Address) Rupert Idaho

15. Filed 6-10, 1930 E W Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1929, to Dec 16, 1929

that I last saw him alive on Dec 16, 1929

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Influenzal (pneumonia Broncho)

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? home

Did an operation precede death? ..... Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Fayre H. Kenagy, M. D.

5-13, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rupert Cemetery L | Date of Burial: Dec 19 1929

20. Undertaker: Rodney Goodman | Address: Rupert Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 17 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

File No. 24536

County of Minidoka

City of Rupert (No. ..... St.)

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Jan (Month) 1 (Day) 1864 (Year)

7. AGE: 64 Yrs. 10 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION: Sheepman & Farmer
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Mt Pleasant Utah

10. NAME OF FATHER: Jens Jensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Catrina Rasmussen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Josiphene Jensen
(Address) Rupert Idaho

15. Filed 6-10 1930 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

916

16. DATE OF DEATH: NOV (Month) 2 1929 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Over 19..., to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 7 15/A M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis

(Duration) about 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Angina Pectoris

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Lelon Frazier M. D.

19..... (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt Pleasant Utah

DATE OF BURIAL: Nov 7 1929

20. UNDERTAKER: W A Goodman

ADDRESS: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20819

PLACE OF DEATH
County of Minidoka
City of Paul
Registration District No. 19
Primary Registration District No. 2015
Local Registrar's No. 24
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Chester Titus

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 13 1870

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	7	24	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Isreal B Titus
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Maria Jakeway
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Vernon H Titus
(Address) Paul Idaho

15. Filed 6-10, 1930 Ed H Thomas Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 7 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1929, to Dec 7 1929
that I last saw him alive on Dec 7 1929
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:
hemiplegia
(duration) ..... yrs. 4 mos. ..... ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) O. B. Barrett M.D.
Dec 8, 1929 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Paul Cemetery	Dec 10 1929
20. Undertaker W. A. Goodman	Address Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Lyle

DO NOT WRITE IN THIS SPACE

State File No. 70646

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

(No. St Joseph Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME Jim Wong

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	Chinese.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66.			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook.

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) China.

PARENTS

10. NAME OF FATHER Wah Fung.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) China.

12. MAIDEN NAME OF MOTHER Ninu Fong Chin.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) China.

14. Informant .....

(Address) Lewiston, Idaho.

15. Filed Apr 1, 1930 S. E. Bruce Registrar

Per J.M. Lyle

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 29th, 1929. 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1929, to Mar, 1930

that I last saw him alive on Mar 29 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pt Hemiplegia

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J.M. Lyle, M. D.

3/30/30, 19.. (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	3/31/20. 19
20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho

Paiute-Goshute

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully [illegible]. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

INDIANBIRD

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JUN 14 1930

1 PLACE OF DEATH
County Bannock State ~~MISSOURI~~ Idaho Registered No. 70830
Township ..... or Village ..... or
City ..... No. ..... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Jimmie Moon

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

705 B

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE Goshute 1/4 Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year) no record

7 AGE Years 10 8 | Months | Days | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None. Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS
10 NAME OF FATHER Burt Moon
11 BIRTHPLACE OF FATHER (city or town) White Pine Co. Nev.
(State or country)
12 MAIDEN NAME OF MOTHER Ethel Long
13 BIRTHPLACE OF MOTHER (city or town) Ruby Valley Nev.
(State or country)

14 Informant L. Hawley
(Address) Chapah Utah

15 Filed June 20, 1930 Bessie N Lepper
State REGISTRAR

11—6184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1929

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
They had no doctor and no undertaker. Had medicine men at Ft Hall.
..... (duration) ..... yrs. 1 mos. ..... ds.
CONTRIBUTORY (SECONDARY) Undetermined
..... (duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? White Pine Co. Nev.
Did an operation precede death? No Date of .....
Was there an autopsy? None
What test confirmed diagnosis? .....
(Signed) E. Hanson, M. D.
, 19 (Address) Sup't & Phys, Paiute

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Goshute Indian Reservation, Utah
DATE OF BURIAL 10-27 1929

20 UNDERTAKER None
ADDRESS

8—200 d
V. S. No. 98

Current Complete October 1929

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JUN 14 1930

70831

1 PLACE OF DEATH
County Bannock State Idaho Registered No. 2
Township ____ or Village ____ or
City Pocatello No. Lynn Bros Hospital St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Sarah Simmons 129

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

Ft Hall Jurisdiction

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Bannock Ind 4/4	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Canamb

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	66	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer ____

9 BIRTHPLACE (city or town) ____
(State or country) Ft Hall Reservation

PARENTAGE

10 NAME OF FATHER Logwite

11 BIRTHPLACE OF FATHER (city or town) ____
(State or country) Ft Hall Reservation

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) Ft Hall Reservation

14 Informant Mrs. Sarah Simmons
(Address) Ft. Hall Idaho

15 Filed June 20, 1930 Bessie N. Lepper REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 — 1929
Treated by Lynn Bros. Pocatello, Idaho
I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:
Interstitial Nephritis

(duration) 3 yrs. ___ mos. ___ ds.
CONTRIBUTORY (SECONDARY) Suppression of urine
(duration) ___ yrs. ___ mos. 1 ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? Analysis of urine
(Signed) Henry R Wheeler, M. D.
,19 (Address) Ft. Hall, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Lytle Cemetery Ft Hall Reservation	10 — 16 — 1929
20 UNDERTAKER Brown & Eldredge	ADDRESS Blackfoot Idaho

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 26

Current Complete November 1929

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JUN 14 1930

1 PLACE OF DEATH — 70832

County Bannock State Idaho Registered No. 5

Township ____ or Village ____ or

City Pocatello No. Lynn Bros. Hospital St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Max. Racehorse 90

(a) Residence. No. ____ St., ____ Ward. ____

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Bannock Ind 4/4	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At hospital

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer

9 BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ____
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Minnie Racehorse

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) Ft. Hall Reservation

14 Informant Minnie Racehorse
(Address) Ft. Hall. Idaho

15 Filed June 20, 1930 Bessie N Lepper State REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1929

I HEREBY CERTIFY, That I attended deceased from Treated Lynn Bros. Pocatello. Idaho

____, 19____, to ____, 19____,

that I last saw h____ alive on ____, 19____,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Defective Cardiac development
Cyanosis

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (SECONDARY) ____

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Blue color

(Signed) Henry R. Wheeler, M. D.

, 19 (Address) Ft. Hall. Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Buttle Cemetery Ft. Hall Reservation	11-26-1929
20 UNDERTAKER	ADDRESS
Agency Carpenter	Ft. Hall. Idaho

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—20068
V. S. No. 26

Ft Hall Jurisdiction

NOT VALID

Current Complete November 1929

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JUN 14 1930

70833

1 PLACE OF DEATH
County Bannock State Idaho Registered No.
Township or Village or
City Pocatello No. Lynn Bros. Hospital St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert Dean Johnson

(a) Residence. No. St., Ward. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred — yrs. — mos. — ds. — How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Shoshone Ind 5/8
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 8, 1929

7 AGE: Years — Months — Days 6 — If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At hospital
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

PARENTS
10 NAME OF FATHER Johnny Johnson
11 BIRTHPLACE OF FATHER (city or town) Inkom
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Lucy Pocatello
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ft. Hall Reservation

14 Informant Johnny Johnson
(Address) Ft. Hall Idaho

15 Filed June 20, 1930 Bessie N. Lepper
State REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1929

17 Treated by Lynn Bros. Pocatello, Idaho
I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at 11 30 P. m.
The CAUSE OF DEATH* was as follows:
Cyanosis — Caused by Defective Cardiac Development.
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Blue Color
(Signed) Henry R. Wheeler, M. D.
, 19 (Address) Ft. Hall Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Bannock Cemetery Ft. Hall Reservation
DATE OF BURIAL: 11-15-1929

20 UNDERTAKER: Johnny Johnny
ADDRESS: Ft. Hall Idaho

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Ft. Hall Jurisdiction

5—200 d
V. S. No. 98

SAMPLE

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70854

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 117

2. FULL NAME Dee Loren Peterson
(a) Residence. No. ~~Montpelier~~ Ovid Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) At Home

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 17-1924

7. AGE Years 4 Months 4 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ovid Idaho

PARENTS
10. NAME OF FATHER Oliver L Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ovid Idaho
12. MAIDEN NAME OF MOTHER Hazel Lindsay
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ovid Idaho

14. Informant Oliver L Peterson
(Address) Ovid Idaho

15. Filed 6/30/, 1930 N H Kerr Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 15 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-12, 1929, to 12-15, 1929
that I last saw h~~e alive~~ on 12-15 1929
and that death occurred, on the date stated above, at 10 45 P m.
The CAUSE OF DEATH* was as follows:
Pus. Appendicitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ovid Idaho
Did an operation precede death? Yes Date of 12-12-29
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) [illegible], M. D.
12-15, 1929 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ovid Idaho Date of Burial Dec 17 1930

20. Undertaker J M Williams Address Montpelier Idaho

TION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70855

PLACE OF DEATH

County of Bear Lake
City of ~~Montpelier~~ Ovid

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

101B

2. FULL NAME Calvin Peterson

(a) Residence. No. Ovid Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 8 - 1928

7. AGE

Years	Months	Days	If LESS than 1 day,
1	2	6	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ovid Idaho

PARENTS

10. NAME OF FATHER Oliver L. Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ovid Idaho
12. MAIDEN NAME OF MOTHER Hazel Lindsay
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ovid Idaho

14. Informant Oliver L. Peterson
(Address) Ovid Idaho

15. Filed 6/30/, 1930. H. H. King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 - 2 (Month) (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30, 1929, to 12 - 2, 1929
that I last saw him alive on 12 - 2, 1929
and that death occurred, on the date stated above, at 9:30 a.m.
The CAUSE OF DEATH* was as follows:

[illegible]

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) [illegible]

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [illegible], M. D.
12 - 2, 1929 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ovid Idaho
Date of Burial: Dec 4 1930

20. Undertaker: [illegible] Williams
Address: Montpelier Idaho

TION is very important. See instruction on back of certificate.

RECEIVED JUN 14 1930

STANDARD CERTIFICATE OF DEATH

Current Complete November 1929

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

70876

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully examined AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Ft. Hall Jurisdiction

1 PLACE OF DEATH
County Ft. Hall Reservation State Idaho Registered No. 2
Township — or Village Ft. Hall or
City — No. Ft. Hall Agency Hospital St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Essawa George

(a) Residence. No. — St., — Ward. 74a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred — yrs. — mos. — ds. — How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Shoshoni Ind. 4/4	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Willie George

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	33	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lemhi Reservation

10 NAME OF FATHER Hoorah Tendoy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lemhi Reservation

12 MAIDEN NAME OF MOTHER Tse-ze-bone

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Montana

14 Informant Georgie Tendoy
(Address) Ft. Hall, Idaho

15 Filed June 20, 1930 Bessie N. Lepper
State REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 — 1929

17 I HEREBY CERTIFY, That I attended deceased from
Nov 19, 1929, to Nov 20, 1929,
that I last saw her alive on Nov 20, 1929,
and that death occurred, on the date stated above, at 7:30 P m.
The CAUSE OF DEATH* was as follows:

Apoplexy, Cerebral

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (SECONDARY)
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Paralysis
(Signed) Henry R Wheeler M. D.
,19 (Address) Ft Hall Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Presbyterian Mission Ft. Hall Reservation	11-25-1929
20 UNDERTAKER	ADDRESS
Brown & Eldredge	Blackfoot Idaho

Current Delayed Complete January 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

REC'D JUL 7 1930

DO NOT WRITE IN THIS SPACE
State File No. 70881

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation
City of Idaho
Registration District No. 121
Primary Registration District No. 21 94
Local Registrar's No. 92

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Tahmanzonah Portneuf

(a) Residence. No. --- St. ....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Charley Portneuf

6. DATE OF BIRTH (month, day and year): 1857

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs, or ....min.
72	---	--	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ....

(c) Name of employer: ....

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Hawz.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Peeyou Elk
(Address) Ft. Hall, Idaho.

15. Filed July 1, 1930 Mrs. R. E. Patent
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 12. 1929
(Month) (Day) (Year)

No Doctor Attending

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw h.... alive on ....., 19....
and that death occurred, on the date stated above, at 9: A m.

The CAUSE OF DEATH* was as follows:

Flu

4 Days
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary): Broncho Pneumonia
2 Days
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry R. McKeen, M. D.

....., 19.... (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Portneuf Cemetery, Ft. Hall Reservation, I-14-29	19

20. Undertaker: H.L. Mc.Han, Address: Pocatello Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71032

PLACE OF DEATH

County of Idaho

City of

Registration District No. 49

Primary Registration District No. 2127

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

5-8a

2. FULL NAME Johnson-Christina Nelson

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) M

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of OM Johnson

6. DATE OF BIRTH (month, day and year) 4-28-1872

7. AGE Years 57 Months 2 Days 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Nelson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Benj B. Johnson (Address)

15. Filed 7/25, 1930 J H Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 27 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to whom, 19

that I last saw her alive on July 27, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) C. H. Bryans, M. D.

July 28, 1929 (Address) Kamiah

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kamiah

Date of Burial 1-30 1930

20. Undertaker Kamiah Funeral Home

Address

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71033

PLACE OF DEATH
County of Kootenai
City of Kamiah
Registration District No. 49
Primary Registration District No. 2129
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

179

2. FULL NAME Pickett, Eliza

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Jan 7

7. AGE — Years 70 | Months 6 | Days 22 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Randolph Co Ind

PARENTS
10. NAME OF FATHER Wenship
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Gray
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mrs A A Schmick
(Address) Kamiah Ida

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 29 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19, 1929 to date 19
that I last saw h[illegible] alive on July 29, 1929
and that death occurred, on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:
Chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? [illegible] Laboratory
(Signed) A B Bryan, M. D.
July 30, 1929 (Address) Kamiah,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kamiah	7-31 1929
20. Undertaker	Address
Kamiah Funeral Home	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JUN 30 19

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 49

Primary Registration District No. ~~2478~~

(No. 2127 St.)

State File No. 71034

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cora E Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word)

6. DATE OF BIRTH: Aug (Month) (Day) 1861 (Year)

7. AGE: 68 Yrs. 11 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Del.

10. NAME OF Father: Case

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Claude Adams

(Address) Kamiah Idaho

15. Filed 7/19 6/25 1930 W Robertson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 90 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1929 to about 19, that I last saw her alive on July 18th 1930, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 7 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A H Bryan M. D.

7/20 1930 (Address) Kamiah

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kamiah

DATE OF BURIAL: 1-20 1930

20. UNDERTAKER: Kamiah Imperial Home

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71040

PLACE OF DEATH

County of Lewis
City of Idaho

Registration District No. 49
Primary Registration District No. 2129
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Chester George

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

11B

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M
4 COLOR OR RACE Ind
5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 23/28

7 AGE Years | Months 6 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Chied
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS
10 NAME OF FATHER Charles George
11 BIRTHPLACE OF FATHER (city or town) (State or country) Idaho
12 MAIDEN NAME OF MOTHER Marlita Davis
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alaska

14 Informant Charles George
(Address) Kamiah Ida

15 Filed 2/2, 1930 J. W. Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February (Month) 1 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1929, to Cheney, 19..., that I last saw him alive on 2/1, 1929, and that death occurred, on the date stated above, at 9:35 p. m.

The CAUSE OF DEATH* was as follows:
Influenza

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) [signature] M. D.
2/2, 1929 (Address) Kamiah, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Kamiah
Date of Burial 2/1 1930

20. Undertaker
Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71041

PLACE OF DEATH
County of Idaho
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. .....

2. FULL NAME L. L. York

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

10/A

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M
4 COLOR OR RACE W
5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sarah York

6 DATE OF BIRTH (month, day and year) 3/14 1875

7 AGE 53 Years | Months 9 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10 NAME OF FATHER York
11 BIRTHPLACE OF FATHER (city or town) (State or country) ?
12 MAIDEN NAME OF MOTHER [illegible]
13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Paul York
(Address) 6/25/30 Kamiah Ida

15 Filed 1/9, 1929 J. W. Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January (Month) 8 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5th, 1929, to 1/8, 1929, that I last saw him alive on Jan. 8th, 1929, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Flu.

..... (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) [illegible], M. D.
1/9, 1929 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Grand View Cem. Ida Co. | Date of Burial 1/10/29 19

20. Undertaker | Address

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 30 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71042

PLACE OF DEATH
County of Lewis
City of Kamiah

CERTIFICATE OF DEATH
Registration District No. 49
Primary Registration District No. 2129
(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

10/a

2. FULL NAME Donald Richard Oatman

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Indian

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day and year) Mch 23, 1928

7 AGE Years Months 9 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kamiah Idaho

PARENTS
10 NAME OF FATHER James Oatman
11 BIRTHPLACE OF FATHER (city or town) (State or country) Idaho
12 MAIDEN NAME OF MOTHER Jane Allen
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho

14 Informant Jane Oatman
(Address) Kamiah Ida

15 Filed 6/16/29, 1929 J W Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January (Month) 5 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 1st, 1929, to Above, 19, that I last saw him alive on Jan. 5th, 1929, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:
Labor Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) , M. D.
Jan. 6th 1929 (Address) [illegible] Kamiah

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Kamiah Ind. | Date of Burial 19

20. Undertaker | Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Ft. Lapwai Indian Agency
Lapwai, Idaho.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JUN 14 1930

71045

1 PLACE OF DEATH
County Idaho State Idaho Registered No.
Township or Village Kooskia or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Zelda Lott Kipp

(a) Residence No. Kooskia St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	3/4 Nez Perce Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 19, 1928

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Kooskia
(State or country) Idaho

PARENTS

10 NAME OF FATHER Joseph Kipp
11 BIRTHPLACE OF FATHER (city or town) Kamiah
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Esther Lott
13 BIRTHPLACE OF MOTHER (city or town) Kooskia
(State or country) Idaho

Informant Esther Lott, Mother
(Address) Kooskia

15 Filed 5/29, 1929 L.A. Medwell REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1929

17 I HEREBY CERTIFY, That I attended deceased from ----------, 19----, to ----------, 19----,
that I last saw h---- alive on ----------, 19----,
and that death occurred, on the date stated above, at ----------m.
The CAUSE OF DEATH* was as follows:

Influenza-pneumonia,
Had no regular attending Physician

---------- (duration) ---- yrs. ---- mos. ---- ds.

CONTRIBUTORY (SECONDARY) ----------
---------- (duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death? ----------
Did an operation precede death? ---------- Date of ----------
Was there an autopsy? ----------
What test confirmed diagnosis? ----------

(Signed) ----------, M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Kooskia Cemetery	April 24 1929
20 UNDERTAKER	ADDRESS
George W. Tenney	Kooskia

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH PEN AND INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

FALSE

RECEIVED JUN 14 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71086

1 PLACE OF DEATH
County Kootenai State Idaho Registered No.
Township or Village Worley or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Okla Mary Pe-ell

49

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Full Spokane Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Pe-ell

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 62 | Months ? | Days | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Coeur d'Alene Res.
(State or country): Idaho

PARENTS

10 NAME OF FATHER: Joseph Conalumqua

11 BIRTHPLACE OF FATHER (city or town): Spokane Res.
(State or country): Washington

12 MAIDEN NAME OF MOTHER: Julia Rosalia

13 BIRTHPLACE OF MOTHER (city or town): Spokane Res.
(State or country): Washington

14 Informant
(Address)

15 Filed June 20, 1930. Bessie N. Lupper
State REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 21 1929, to Jan. 23 1929,
that I last saw her alive on Jan. 23, 1929,
and that death occurred, on the date stated above, at 12 p. m.
The CAUSE OF DEATH* was as follows:

Cancer

(duration) 1 yrs. ? mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Jan. 22
Was there an autopsy? no
What test confirmed diagnosis? chemical

(Signed) H. E. WHEELER, M. D.
, 19 (Address) Spokane, Washington

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetery	Jan. 26 1929
20 UNDERTAKER: H. Jaeger	ADDRESS: Plummer, I

VOID

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

RECEIVED JUN 14 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71094

1 PLACE OF DEATH
County Latah State Idaho Registered No. 128
Township ..... or Village Juliaetta, Ida. or
City ..... No. ....., ... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Estella Seven

(a) Residence. No. Juliaetta, Ida St., ... Ward. 146
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
20	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Juliaetta
(State or country) Ida

PARENTS
10 NAME OF FATHER Jack Seven
11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Ellen Seven
13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Idaho

14 Informant Mollie Seven Daniels
(Address) Juliaetta, Idaho

15 Filed Feb 21, 1929 L A Maxwell
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1929

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:
Puerperal Septicemia
Had no physician. Died very suddenly after birth of child (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) ....., M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Family Cemetery
DATE OF BURIAL: Feb. 22 1929

20 UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

RECEIVED JUN 14 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71095

1 PLACE OF DEATH
County Latah State Idaho Registered No.
Township or Village Juliaetta & Vicinity or
City No. St. Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ipsnowyahtahmotsonmy
(a) Residence. No. Juliaetta, Ida St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: 1/4 Nez Perce Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abel Williams

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE: Years 73; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Nez Perce Reservation
(State or country): Idaho

PARENTS

10 NAME OF FATHER: Tiska

11 BIRTHPLACE OF FATHER (city or town): Unknown
(State or country): Idaho

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): "
(State or country): "

14 Informant: Norbert B. Sawyer - Clerk
(Address): Lapwai, Ida.

15 Filed Aug. 9, 1929 W. M. Maxwell REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 8 1929

17 I HEREBY CERTIFY, That I attended deceased from ----------, 19----, to ----------, 19----,
that I last saw h---- alive on ----------, 19----,
and that death occurred, on the date stated above, at ----------m.
The CAUSE OF DEATH* was as follows:

(a) Bronchopneumonia

(duration) ---- yrs. ---- mos. 10 ds.

CONTRIBUTORY (SECONDARY)

(duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Gaignard, M. D.
, 19 (Address) Culdesac, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Juliaetta Cemetery	Aug. 9 1929
20 UNDERTAKER	ADDRESS
Brower-Nunn Co.	Lewiston, Ida

INDIAN BU.

Ft. Lapwai Indian Agency
Lapwai, Idaho

RECEIVED JUN 14 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71110

1 PLACE OF DEATH
County Lewis State Idaho Registered No.
Township Nez Perce Reservation or Village Kamiah or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lottie Frank Kipp

31

(a) Residence. No. Kamiah, Ida. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Kipp

6 DATE OF BIRTH (month, day, and year): 1906

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
22	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kamiah
(State or country) Idaho

PARENTS
10 NAME OF FATHER Willie B. Frank
11 BIRTHPLACE OF FATHER (city or town) Kamiah
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Rachel Monteith
13 BIRTHPLACE OF MOTHER (city or town) Kamiah
(State or country) Idaho

14 Informant Corbett B. Lawyer-Clerk
(Address) Lapwai, Ida

15 Filed 3/18, 1929 L. P. Maxwell
Clerk REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs,
Had no regular attending
Physician
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Kamiah Cemetery
DATE OF BURIAL: Mar. 19, 1929

20 UNDERTAKER: C. A. Johnson
ADDRESS: Kamiah

INDIAN DU

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

RECEIVED JUN 1 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

7111

1 PLACE OF DEATH
County Lewis State Idaho Registered No.
Township or Village Kamiah or
City No. St. Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)
Ft. Lapwai Indian Agency
Lapwai, Idaho,

2 FULL NAME Peter Gould

(a) Residence. No. Kamiah, Ida St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	¼ Nez Perce Indian	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Hattie Axtell

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	66	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

INDIAN

9 BIRTHPLACE (city or town) Nez Perce Reservation
(State or country) Idaho

PARENTS

10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) "
(State or country) "
12 MAIDEN NAME OF MOTHER "
13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Hattie Axtell Gould - Wife
(Address) Kamiah Ida.

15 Filed 6/4/, 1929 E. Maxwell
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1929

17 I HEREBY CERTIFY, That I attended deceased from May, 1925, to April 28, 1929, that I last saw him alive on April 28th, 1929, and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH was as follows:

Progressive muscular atrophy
Spinal (Wasting palsy)

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Bryan, M. D.
6/4/, 1929 (Address) Kamiah, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Kamiah Cemetery	April 30 1929
20 UNDERTAKER C. A. Johnson	ADDRESS Kamiah

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

RECEIVED JUN 14 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71116

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 128
Township ..... or Village Lapwai or
City ..... No. ....., ... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Green

100a

(a) Residence. No. Lapwai St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) Nov. 18, 1928

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	1	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9 BIRTHPLACE (city or town) Lapwai
(State or country) Idaho

PARENTS
10 NAME OF FATHER Joseph Green
11 BIRTHPLACE OF FATHER (city or town) Slickpoo
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Cecelia Raymond
13 BIRTHPLACE OF MOTHER (city or town) Webb
(State or country) Idaho

14 Informant Corbett B. Lawyer - Clerk
(Address) Lapwai, Ida.

15 Filed Jan. 21, 1929 L. A. Maxwell
Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
..... (duration) ..... yrs. ..... mos. 9 ds.
CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unable to say
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) George Gaignard, M. D.
, 19 (Address) Culdesac, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Lapwai Cemetery
DATE OF BURIAL: Jan. 18 1929
20 UNDERTAKER: Brower-Wann Co.
ADDRESS: Lewiston

INDIAN BU.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

Ft. Lapwai Indian Agency
Lapwai, Idaho.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71117

JUN 14 1930

1 PLACE OF DEATH

County Nez Perce State Idaho Registered No.

Township Nez Perce Reservation or Village Culdesac 3rd Vicinity or

City No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Nellie Daniel

(a) Residence. No. Culdesac, Ida St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: 4/4 Nez Perce Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Ahpostimnah

6 DATE OF BIRTH (month, day, and year): 1868

7 AGE: Years 60 | Months — | Days — | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Nez Perce Res. Idaho

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant (Address): Corbett B. Lawyer Lapwai, Idaho

15 Filed 3/21, 1929 L. A. Maxwell REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 1st 1929

17 I HEREBY CERTIFY, That I attended deceased from ----, 19---, to ----, 19---,

that I last saw h---- alive on ----, 19---,

and that death occurred, on the date stated above, at ---- m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

No regular attending physician reported

(duration) 3 yrs. ---- mos. ---- ds.

CONTRIBUTORY (SECONDARY) ----

(duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ---- Date of ----

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ----, M. D.

, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Family Cemetery

DATE OF BURIAL: 3/4/ 1929

20 UNDERTAKER: Brower-Wann Co

ADDRESS: Lewiston

INDIAN DU.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JUN 14 1930

71118

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Lapwai or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

REGISTER B-D
CENSUS ROLL
DEGREE BLOOD

11 B

2 FULL NAME Na-we-not
(a) Residence. No. Lapwai, Idaho St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colville Ind. 4/4
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?
6 DATE OF BIRTH (month, day, and year) 1842
7 AGE: Years 86 | Months | Days | If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Invalid
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS
10 NAME OF FATHER "
11 BIRTHPLACE OF FATHER (city or town) (State or country) "
12 MAIDEN NAME OF MOTHER "
13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mrs. Esther J. Corbett
(Address) Lapwai Idaho

15 Filed 1-7-29 L. A. Maxwell Clerk REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-6-29 19

17 I HEREBY CERTIFY, That I attended deceased from , 19, to , 19,
that I last saw her alive on 1-6-29, 19,
and that death occurred, on the date stated above, at 10.00 a. m.
The CAUSE OF DEATH* was as follows:
Influenza - Had no attending Physician
(duration) mos. 6 ds.
CONTRIBUTORY (SECONDARY) not known
(duration) yrs. mos. ds.
18 Where was disease contracted if not at place of death? Unable to say
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Spalding Indian Cem.
DATE OF BURIAL: 1-7-29 19
20 UNDERTAKER: Brower-Hann Co.
ADDRESS: Lewiston Ida.

INDIAN BU.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71119

JUN 14 1930

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 128
Township ..... or Village Lapwai or
City ..... No. ....., ... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Sally Wilber

(a) Residence. No. Stites, Idaho St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

11 B

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Jim Wilber

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
88	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Nez Perce, Res.
(State or country) Idaho

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) "
(State or country) "
12 MAIDEN NAME OF MOTHER "
13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) "

14 Informant Josiah Red Wolfe
(Address) Lapwai, Ida.

15 Filed Jan. 14, 1929 L. A. Maxwell
Clerk REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1929

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw her alive on January 14, 1929, and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:
Influenza
Had no regular attending physician
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Broncho-pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unable to say
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) ....., M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Stites Indian Cemetery
DATE OF BURIAL: Jan 1929

20 UNDERTAKER: Brower-Wann Co.
ADDRESS: Lewiston

INDIAN

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71129

RECEIVED JUN 14 1930

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 128
Township ..... or Village Lapwai & Vicinity or
City ..... No. ....., ... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Emma Lawyer

(a) Residence. No. Lapwai, Idaho St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

31

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Charles Williams

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
66	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Invalid
(c) Name of employer

9 BIRTHPLACE (city or town) Kamiah
(State or country) Idaho

PARENTS
10 NAME OF FATHER Yol-mah-hoo-sutes
11 BIRTHPLACE OF FATHER (city or town) Nez Perce Res
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Tomi-Kommy
13 BIRTHPLACE OF MOTHER (city or town) Nez Perce Res
(State or country) Idaho

14 Informant Corbett B Lawyer
(Address) Lapwai, Idaho

15 Filed Jan 8, 1929 L A Maxwell
Clerk REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 1929

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw her alive on Jan. 7, 1929,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unable to say
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) George Gaisnard, M. D.
8/26/1929 (Address) Culdesa, Ida

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Spalding Indian Cemetery
DATE OF BURIAL: Jan. 10 1929

20 UNDERTAKER: Brower Wann Co
ADDRESS: Lewiston

INDIAN BU.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

Ft. Lapwai Indian Agency
Lapwai, Idaho

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71121

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Agatha or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

1000

2 FULL NAME Charles Spaulding

(a) Residence. No. Agatha, Ida. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	1/4 Nez Perce Indian	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Not known

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Agatha
(State or country) Idaho

10 NAME OF FATHER Tom Spaulding

11 BIRTHPLACE OF FATHER (city or town) Nez Perce Res.
(State or country) Idaho

12 MAIDEN NAME OF MOTHER We-yat-wy

13 BIRTHPLACE OF MOTHER (city or town) Nez Perce Res.
(State or country) Idaho

14 Informant Philip Williams
(Address) Lapwai, Ida.

15 Filed May 8, 1929 L. L. Maxwell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from ----------, 19----, to ----------, 19----,
that I last saw h---- alive on ----------, 19----,
and that death occurred, on the date stated above, at ----------m.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia
Had no regular attending Physician

---------- (duration) ---- yrs. ---- mos. 15 ds.

CONTRIBUTORY ----------
(SECONDARY)
---------- (duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death? Unable to say
Did an operation precede death? No Date of ----------
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) ----------, M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Family Cemetery	May 9, 1929
20 UNDERTAKER	ADDRESS
Brower-Nunn Co.	Lewiston

11—3184 GOVERNMENT PRINTING OFFICE

8—209 d
V. S. No. 98

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

DUPLICATE

RECEIVED JUN 14 1929

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71122

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Sweetwater or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Ft. Lapwai Indian Agency
Lapwai, Idaho.

2 FULL NAME Jane Pelatayakot

(a) Residence. No. Sweetwater, Ida St., Ward. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
78	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

INDIAN BU

9 BIRTHPLACE (city or town) Nez Perce Reservation
(State or country) Idaho

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Dr. George Gaignard
(Address) Culdesac, Ida.

15 Filed July 25, 1929 F. Maxwell
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1929

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
Died very suddenly.
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) George Gaignard, M. D.
9/16, 1929 (Address) Culdesac, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Sweetwater Cemetery
DATE OF BURIAL: July 27 1929

20 UNDERTAKER: Brower-Wann Co.
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
71193

RECEIVED JUN 14 1930

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village or
City Lewiston No. St. Josephs Hospital St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ruth Becklett Rickman

(a) Residence. No. Lucetwater, Ida St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	1/4 Nez Perce Indian	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Joe Elmo Rickman

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	36	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kamiah
(State or country) Idaho

PARENTS
10 NAME OF FATHER Sam Becklett
11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Nellie Waters
13 BIRTHPLACE OF MOTHER (city or town) Kamiah
(State or country) Idaho

14 Informant Beulett B. Lawyer Clerk
(Address) Lapwai Ida.

15 Filed Aug 30, 1929 [signature] REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1929

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to Aug. 29, 1929,
that I last saw h-er alive on Aug. 29, 1929,
and that death occurred, on the date stated above, at ---- m.
The CAUSE OF DEATH* was as follows:

(a) Brain Abscess

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JUL 9 1930

Registered No. 21144

1 PLACE OF DEATH
County Idaho State Idaho
Township ____ or Village Kamiah or
City ____ No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Albert Edward Davis

(a) Residence. No. Kamiah St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	1/4 Nez Perce Indian	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Etta Moffett

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kamiah
(State or country) Idaho

PARENTS
10 NAME OF FATHER James E. Davis
11 BIRTHPLACE OF FATHER (city or town) Cheshire
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Susan Blackeagle
13 BIRTHPLACE OF MOTHER (city or town) Kamiah
(State or country) Idaho

14 Informant Charlotte B. Lawyer-Clerk
(Address) Lapwai, Ida.

15 Filed Nov. 18, 1929 L. M. Maxwell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16" 1929

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY)
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ____ Date of ____
Was there an autopsy?
What test confirmed diagnosis?

(Signed) ____, M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Kamiah Cemetery	Nov. 19 1929
20 UNDERTAKER	ADDRESS
The Kamiah Funeral Home	Kamiah

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

11—3184 GOVERNMENT PRINTING OFFICE

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71145

1 PLACE OF DEATH
County Idaho State Idaho Registered No.
Township RECEIVED JUL 9 1930 or Village Stites or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Jesse Williams James

66

(a) Residence. No. Stites, Idaho St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia Scott

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
53	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kamiah Idaho

PARENTS
10 NAME OF FATHER: Jesse Hart James
11 BIRTHPLACE OF FATHER (city or town) (State or country): Kamiah Idaho
12 MAIDEN NAME OF MOTHER: Sally James
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kamiah Idaho

14 Informant: Corbett B. Lawyer - Clerk
(Address) Lapwai Idaho

15 Filed Nov. 20, 1929 L. A. Maxwell REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 18" 1929

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Acute Alcoholism
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Stites Cemetery
DATE OF BURIAL: Nov. 21 1930

20 UNDERTAKER: Geo. W. Trenary
ADDRESS: Kooskia

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

RECEIVED JUL 9 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71146

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township Ft. Lapwai Indian Agency or Village Spaulding or
City Lapwai, Idaho No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elias Pond

100a

(a) Residence. No. Spaulding, Idaho St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Pond

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 64 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Preacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10 NAME OF FATHER: Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country): "
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Corbett B Lawyer - Clerk
(Address) Lapwai, Idaho

15 Filed 12/24/1929 L. Maxwell
REGISTRAR

11—6184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 24 1929

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,
that I last saw h alive on , 19 ,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Spaulding Cemetery
DATE OF BURIAL: Dec. 30 1929

20 UNDERTAKER: Brower-Warm Co.
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 96

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71156

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Culdesac Vicinity or
City RECEIVED JUL 9 1930 No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret Mary Higheagle
(a) Residence. No. Culdesac, Ida. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

705 B

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 12, 1929

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	1	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lewiston
(State or country) Idaho

PARENTS
10 NAME OF FATHER Antoine Higheagle
11 BIRTHPLACE OF FATHER (city or town) Kamiah
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Josephine Luke
13 BIRTHPLACE OF MOTHER (city or town) Slickpoo
(State or country) Idaho

14 Informant Antoine Higheagle - Father
(Address) Culdesac, Ida.

15 Filed Dec. 5, 1929 F. Maxwell Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3rd 1929

17 I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19...., that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:
Cause of death not Known
had no physician

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) ....., M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Slickpoo Mission
DATE OF BURIAL: Dec. 6 1929
20 UNDERTAKER: Brower-Wann Co.
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 96

11—6194 GOVERNMENT PRINTING OFFICE

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

7175

1 PLACE OF DEATH JUN 14 1930
County Western Shoshone Reservation State Nevada-Idaho Registered No.
Township ____ or Village ____ or
City ____ No. Western Shoshone Hospital St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Viola Smith

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate. Western Shoshone Res.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	Indian 4/4	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 11,1917

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	11	3	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Western Shoshone Reservation
(State or country)

PARENTS

10 NAME OF FATHER Billy Smith
11 BIRTHPLACE OF FATHER (city or town) Nevada
(State or country) Shoshone
12 MAIDEN NAME OF MOTHER Minnie Dick
13 BIRTHPLACE OF MOTHER (city or town) West Shosho. Res
(State or country) Shoshone

14 INFORMANT Office Records
Address

15 FILED June 20, 1930 Bessie N Lepper
State REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

V. S. No. 98 8—200 d

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4,1929. 19

17 I HEREBY CERTIFY, That I attended deceased from
Januar ,1929 19____, to March 4,1929, 19____,
that I last saw h er alive on March 4,1929, 19____,
and that death occurred, on the date stated above, at 4.20 P m.
The CAUSE OF DEATH* was as follows:

Infection

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY)
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical symptoms

(Signed) B M Hamilton, M. D.
3/4, 1930 (Address) Owyhee, Nevada

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Owyhee, Nevada	3/6/29. 19
20 UNDERTAKER Ed Davis, Owyhee, Nevada.	ADDRESS

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JUN 14 1930

Registered No. 7176

1 PLACE OF DEATH
County Western Shoshone Reservation State Nevada-Idaho.
Township Unorganized or Village or
City No. Western Shoshone Hospital, St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harris Blackhat

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Indian 4/4	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-29-27

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	1	7	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Western Shoshone Res.
(State or country) 2/4Paiute2/4Shoshone

10 NAME OF FATHER Georgs Blackhat

11 BIRTHPLACE OF FATHER (city or town) West.Sho.Res
(State or country) Shoshone

12 MAIDEN NAME OF MOTHER Ruby Egan

13 BIRTHPLACE OF MOTHER (city or town) West.Sho.Res.
(State or country) Paiute.

14 Informant Records of Agency
(Address)

15 Filed June 20, 1930 Bessie N Lepper REGISTRAR
11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13/29. 19

17 I HEREBY CERTIFY, That I attended deceased from February 27, 1929, to March 13, 1929,
that I last saw him alive on March 13, 1929, 19,
and that death occurred, on the date stated above, at 10 A.m.
The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (SECONDARY) Lack of proper care and nursing
(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) G M H Hamilton, M. D.
3/13 19 29 (Address) Owyhee, Nevada.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19

20 UNDERTAKER	ADDRESS
Ed Davis, Owyhee, Nevada, Not a licensed undertaker bu maker of box for burial.	

COPY

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Western Shoshone Reservation.

8—269 d
V. S. No. 98

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Western Shoshone Reservation

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

7117

1 PLACE OF DEATH RECEIVED JUN 14 1930

County Western Shoshone Reservation State Nevada-Idaho Registered No.

Township Unorganized or Village or

City No. Western Shoshone St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Wilford Smith 112

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Indian 4/4

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 16, 1922.

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
7		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West Shoshone Reservation
(State or country) Shoshone

PARENTS

10 NAME OF FATHER Pits Smith

11 BIRTHPLACE OF FATHER (city or town) West. Sho. Res.
(State or country) Shoshone

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town) West. Shosh. Res.
(State or country) Shoshone

14 Informant Office records.
(Address)

15 Filed June 20, 1930 Bessie N. Lepper REGISTRAR
State

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21/29. 19

17 I HEREBY CERTIFY, That I attended deceased from January 30, 1929, to February 21, 1929, that I last saw him alive on February 21, 1929, 19, and that death occurred, on the date stated above, at 3:55 P. m.

The CAUSE OF DEATH* was as follows:

Acute indigestion

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (SECONDARY) Uremia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) J. M. Hamilton, M. D.

7/22, 19 27 (Address) Owyhee Nevada

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

INDIAN BUR.

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER Ed Davis	ADDRESS Owyhee, Nev.

No licensed undertaker here.

RECEIVED AUG 9 1930

Delayed Complete Dec. 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71318

PLACE OF DEATH

County of Ft. Hall Reservation Registration District No. 121
City of Idaho. Primary Registration District No. 2194-R Local Registrar's No. 95
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ethel Wenee. 1050

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Bannock Ind. 4/4	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6. DATE OF BIRTH (month, day and year) 12- 14- 28.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	I	II	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft. Hall Reservation

PARENTS

10. NAME OF FATHER Carl Wenee

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemhi Reservation

12. MAIDEN NAME OF MOTHER Ruth Burt

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ft. Hall Reservation

14. Informant Ruth Wenee.
(Address) Ft. Hall, Idaho

15. Filed July 15, 1930 Mrs Walter E. Patrie
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 9, 1929.
(Month) (Day) (Year)

No Doctor Attending.

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at 7 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia- Bronchial

6 days
.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) ---
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? --
Did an operation precede death No Date of
Was there an autopsy? No
What test confirmed diagnosis? None. Information

(Signed) Henry R. Wheeler M. D.
....., 19..... (Address) Ft. Hall, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ft. Hall Reservation	--- 19

20. Undertaker Jeff Burt Ft. Hall, Idaho

Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

Delayed Complete

Dec. 1929.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71319

PLACE OF DEATH — CERTIFICATE OF DEATH

County of Ft. Hall Reservation Registration District No. 121
City of Idaho Primary Registration District No. 2194-R. Local Registrar's No. 96
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Catherine Ariwite

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Shoshone Ind. 4/4
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6. DATE OF BIRTH (month, day and year) March 1, 1929.

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): At home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Blackfoot, Idaho

PARENTS

10. NAME OF FATHER: Benjamin Arawite
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Salmon City, Idaho
12. MAIDEN NAME OF MOTHER: Hattie Honena
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Salmon City, Idaho

14. Informant: Benjamin Ariwite
(Address): Ft. Hall, Idaho

15. Filed July 15 1930 Walter E. Petrie Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 15, 1929 (Month) (Day) (Year)
Treated by Dr. Mitchell, Blackfoot

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 7. A ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia- bronchial

6 days (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY --- (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phys. signs

(Signed) Henry R. Whalen M. D.
....., 19..... (Address) Ft. Hall, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
****** Butte Cem.	12/17/29 19

20. Undertaker: Brown-Eldredge, Blackfoot, Ida
Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. RECEIVED SEP 2 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 71722

Local Registrar's No.

1. PLACE OF DEATH
County of Gooding
City of Wendell
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Rowe Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Oct (Month) 29 (Day) 1866 (Year)

7. AGE: 62 Yrs. 4 Mos. 15 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF Father: Peter Moore

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Rowe

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs A. R. Moore
(Address): Wendell Ida

15. Filed Mar 14 1929 E L Simanton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 14 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1928 to Mar 14 1929
that I last saw him alive on Mar 9 1929
and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:
Cardio Vascular disease

(Duration) 5 yrs. — mos. — ds.

Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) E. L. Simanton M. D.
3-14-1929 (Address) Wendell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....19....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Johnson.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71811

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. St Joseph Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

11a

2. FULL NAME Jennie H. Risher.

(a) Residence. No. 508 Delsol Lane. ~~St.~~

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: L. E. Risher.

6. DATE OF BIRTH (month, day and year): 8/3/1855.

7. AGE: Years 73. Months 6. Days ---- If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ohio.

PARENTS

10. NAME OF FATHER: Jewell.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known.

14. Informant: L. E. Risher

(Address) Lewiston, Idaho.

15. Filed 3-1-, 1929 S. E. Bruce Per M L Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 3rd, 1929. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Feb 2, 1929, to Feb 3, 1929

that I last saw her alive on Feb 2, 1929

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Influenza - & Broncho-pneumonia

(duration) yrs. 4 wks. mos. ds.

CONTRIBUTORY (Secondary): Chronic nephritis

(duration) yrs. years mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul W. Johnson, M. D.

2/4/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 2/5/29. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71812

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

72

2. FULL NAME Frank Marshall.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 6th, 1876.

7. AGE Years: 52. Months: 10. Days: 25. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Day laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Canada.

PARENTS

10. NAME OF FATHER: John Marshall.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Mary Ann Stutt.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada.

14. Informant: St Joseph Hospital Records.
(Address) Lewiston, Idaho.

15. Filed Sept 12, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 1st, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1926 to July 30, 1929
that I last saw him alive on July 30, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Tabes Dorsalis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. M. Lyle, M. D.
8/3/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 8/3/29. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71813

PLACE OF DEATH

County of New Perce.

City of Lewiston.

Registration District No. 95

Primary Registration District No. 1009

Local Registrar's No.

(No. Lewiston Orchards.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Elias H. Harsh.

(a) Residence. No. Lewiston, Orchards. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1/30/1860.

7. AGE: 39. Years | Months: 6. | Days: 13. | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10. NAME OF FATHER: George Harsh.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Mary Irvine.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Va.

14. Informant: Bert M. Wright.
(Address) Lewiston, Idaho.

15. Filed Sept 12, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 13th, 1929. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1928, to July, 1929
that I last saw him alive on July, 1929
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Aortic insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J M Lyle, M. D.

8/14/29, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. | Date of Burial: 8/15/29. 19

20. Undertaker: Brower-Wann Company. | Address: Lewiston, Idaho.

FORM V. S. No. 5-25 M. 1-19. RECEIVED DEC 11 1930

CERTIFICATE OF DEATH F

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

File No. 72856

Registered No. 62

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rebeca A. Becker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Sept (Month) 26 (Day) 1874 (Year)

7. AGE: 54 Yrs. 11 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: William H Rose

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary Folley

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jane Becker

(Address) Rupert Idaho

15. Filed Nov. 6 1930 E W Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2 (Day) 1929 (Year) 131

17. I HEREBY CERTIFY, That I attended deceased from July 16 1928, to Aug 2" 1929, that I last saw her alive on July 27 1929, and that death occurred on the date stated above, at 8 40 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(Duration) about 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cystic Kidney

(Duration) about 1 yrs. ..... mos. ..... ds.

(Signed) Leland Frazier M. D.

19 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery

DATE OF BURIAL: Aug 4 1929

20. UNDERTAKER: W. J. Goodman

ADDRESS: Rupert Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72860

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
Local Registrar's No. 66
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

45

2. FULL NAME Margaret E. Hoopes
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of H. R. Hoopes

6. DATE OF BIRTH (month, day and year) April 25 1866

7. AGE: Years 63 | Months 7 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10. NAME OF FATHER: Frank Spindell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Mary Ann Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: H. R. Hoopes
(Address) Rupert Idaho

15. Filed Nov. 6, 1930 Elt Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 20 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24, 1929, to Dec 20, 1929
that I last saw her alive on Dec 19, 1929
and that death occurred, on the date stated above, at 7 17/A m.
The CAUSE OF DEATH* was as follows:
Carcinoma Descending Colon
about 1 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of about Feb. 1929 (Nov. only rec)
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Leland Frazier, M. D.
....., 19..... (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rupert Cemetry | Date of Burial: Dec 22 1929

20. Undertaker: W. A. Goodman | Address: Rupert Idaho

Ft.Hall Jurisdiction

Delayed Complete

November 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 13027

RECEIVED JAN 5 1931

PLACE OF DEATH

County of Bingham

City of Ft.Hall Reser'vn. Registration District No. 121

Primary Registration District No. 2194 Local Registrar's No. 175

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hesheeshigge

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Shoshone Ind. 4/4	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Snooks Mosho

6. DATE OF BIRTH (month, day and year) 1859

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	-	-	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ft.Hall Reservation

PARENTS

10. NAME OF FATHER Penquinjim

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ft.Hall Reservation

12. MAIDEN NAME OF MOTHER Pashwah

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ft.Hall Reservation

14. Informant Stella Mosho
(Address) Ft.Hall, Idaho

15. Filed Dec.30, 1930 Mr Mattie E. Pettit
Registrar.

MEDICAL CERTIFICATE OF DEATH 31

16. DATE OF DEATH November 18, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29, 1929, to Nov. 18, 1929,
that I last saw her alive on Nov. 15, 1929,
and that death occurred, on the date stated above, at 8:P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs.

Date of Onset: 2/II/29

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Phys. signs

(Signed) Jerome P. Whitcher M. D.
....., 19..... (Address) Ft.Hall, Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Bannock cem. Ft.Hall Res.	II/20/29 19

20. Undertaker	Address
Agency Carpenter,	Ft.Hall, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

PHYSICIAN

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1231

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116

Local Registrar's No.

(No. 46)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace Etta Bell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chas. A. Bell

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
43	10		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER George P. Conlee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Emma J. Pattison
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs. F. W. Bellamy
(Address) Salmon Idaho

15. Filed Jan. 10, 1931 Cliff C. Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 2 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to Nov 2, 1929
that I last saw h[illegible] alive on Sept 30, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Cancerous Uterus

1
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Salmon, Idaho
Did an operation precede death? Yes Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? Pathological
(Signed) [illegible] M. D.
....., 19..... (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	Nov. 3 1930
20. Undertaker	Address
Wm. C. Doubles	Salmon Idaho

Ft.Hall Jurisdiction, Delayed, Complete Nov. 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 74359

PLACE OF DEATH
County of Ft.Hall Reservation Idaho.
City of

CERTIFICATE OF DEATH
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 37
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alfred Wettembonne

(a) Residence. No. ---- St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Shoshone Ind. 4/4	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of -----

6. DATE OF BIRTH (month, day and year) Nov 18, 1929.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) ---
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft.Hall Reservation

PARENTS

10. NAME OF FATHER Ray Wettembonne

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemhi Reservation

12. MAIDEN NAME OF MOTHER Julia Partridge

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ft.Hall Reservation

14. Informant (Address) Julia Wettembonne Ft.Hall, Idaho.

15. Filed March 29 31 Mrs Mallie E. Patrie Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 22, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Doctor attending, 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 6:P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Atelectasis of lungs

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Henry R. Wheeler, M. D.
19... (Address) Ft.Hall, Id

19. Place of Burial, Cremation, or Removal: Presbyterian Mission, Ft.Hall, Idaho, Date of Burial: 11/24/29

20. Undertaker: Ray Wettembonne, Ft.Hall, Idaho. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

Ft.Hall Jurisdiction Delayed Complete Nov.1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 74360

PLACE OF DEATH — **CERTIFICATE OF DEATH**

County of Ft.Hall Reservation Registration District No. 121
City of Idaho Primary Registration District No. 2194 Local Registrar's No. 38
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Iola Bear 31

(a) Residence. No. ---- St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 0 yrs. 10 mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Bannock Ind. 4/4	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6. DATE OF BIRTH (month, day and year) Jan.10, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	10	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) --
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft.Hall Reservation

PARENTS

10. NAME OF FATHER Little White Bear

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia City, Montana

12. MAIDEN NAME OF MOTHER Ella Eagle

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Lemhi Reservation

14. Informant (Address) Little White Bear, Ft.Hall, Idaho.

15. Filed March 29 1931 Mon Walter E. Patrick Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 11, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Doctor attending ....19.... to ....19....
that I last saw h.... alive on ....19....
and that death occurred, on the date stated above, at 11P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs
Onset 10/I/1929

....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Henry R. Wheeler, M. D.
-- ....19.... (Address) Ft. Hall, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lincoln Creek, Ft.Hall Reservation	11/14/29 19
20. Undertaker	**Address**
Brown & Eldredge,	Blackfoot, Ida.

Every item or information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 11 1933

STATE OF IDAHO Delayed. Certificate

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 85539

PLACE OF DEATH

County of Bingham

City of Fort Hall Res.

Registration District No. 121-R

Primary Registration District No. 2194-R

Local Registrar's No. 107

(No. No Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Belle Navo.

(a) Residence. No. Ft. Hall, Idaho. St.
(Usual place of abode) (If nonresident give city or town and state)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Sho. & Bann.
5. Single, Married, Widowed, or Divorced (write the word): 3/4 Single

5a. If maried, widowed, or divorced HUSBAND of (or) WIFE of: None

6. DATE OF BIRTH (month, day, and year): June 6, 1923

7. AGE: Years 5, Months 11, Days 3. If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookeeper, etc: None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc: None

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Ft. Hall, Idaho

FATHER

13. NAME: Charles Navo.

14. BIRTHPLACE (city or town) (State or country): Ft. Hall Res. Idaho

MOTHER

15. MAIDEN NAME: Zuni Whitebear.

16. BIRTHPLACE (city or town) (State or country): Ft. Hall Res. Ida.

17. INFORMENT (Address): Connaway & Lillie Navo. Ft. Hall, Idaho.

18. BURIAL, ~~CREMATION~~, OR ~~REMOVAL~~ Place: Lincoln Cemetery Date: May 12, 1929

19. UNDERTAKER (Address): Gem State Lumber Co. Blackfoot, Idaho.

20. FILED Aug. 18, 1933 Mrs Walter E. Palmer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year): May 9, 1929

22. I HEREBY CERTIFY, That I attended deceased from No Doctor in, 193..., to Attendance, 193...

I last saw h..... alive on ....., 193...: death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Measles.	1 week
Pneumonia, Lobar.	1 week

Other contributory causes of importance:

Name of operation: None Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to exter'l causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 193

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) E. J. Whitebear, M. D.

(Address) Fort Hall, Idaho

MARGIN RESERVED FOR BINDING

N. B.---WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1934

Delayed.

PLACE OF DEATH

County of Fort Hall Res.

City of .....

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 88965

Registration District No. I2I-R

Primary Registration District No. 2I94-R

Local Registrar's No. 80

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number)

1000

2. FULL NAME Cynthia Bear

(a) Residence. No. Fort Hall Reservation St. .....

(Usual place of abode) (If nonresident give city or town and state)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. Color or Race Bannock Ind. 4/4

5. Single, Married, Widowed or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of - - - - -

6. DATE OF BIRTH (month, day, and year) - - - - - - -

7. AGE Years 2 Months 5 Days 3 If LESS than 1 day,... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as **spinner, sawyer, bookkeeper, etc.** None

9. Industry or business in which work was done, as **silk mill, saw mill, bank, etc.** None

10. Date deceased last worked at this occupation (mo. and yr.) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) ..... (State or country) Fort hall Reservation

FATHER

13. NAME Little White Bear

14. BIRTHPLACE (city or town) Virginia City, Montana (State or country)

MOTHER

15. MAIDEN NAME Ella Eagle

16. BIRTHPLACE (city or town) Lemhi Res. Ida. (State or country)

17. INFORMANT Ella Eagle Bear (Address) Fort Hall Reservation

18. BURIAL, CREMATION OR REMOVAL Place Presby. Mission Date June 22, 1929

19. UNDERTAKER Brown-Eldredge (Address) Blackfoot, Idaho

20. FILED June I, 1932 Wm. Walter E. Patrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day and year) June 19 1929 Jun. ~~XXXX~~

22. I HEREBY CERTIFY, That I attended deceased from No Doctor attending, 193..., to ....., 193....

I last saw h....alive on ....., 193...: death is said to have occurred on the date stated above, at 8:P....m.

The **principal cause of death** and related causes of importance were as follows:

	Date of onset
Bronchial Pneumonia	1929 May ~~1932~~

Other **contributory causes** of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis?.... Was there an autopsy?..

23. If death was due to exter'l causes **(violence)** fill in also the following:

Accident, suicide, or homicide?..... Date of injury.., 193.

Where did injury occur? ..... (Specify city or town, county, and state)

Specify whether injury occurred in **industry**, in **home**, or in **public place.** .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? E. J. Whittleman (Signed) ..... M. D.

(Address) Fort Hall

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.